

**SELECTED PAPERS**  
2003–2005

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# PREFACE

The Millennium Development Goals represent an unprecedented commitment to tackle the most basic forms of injustice and inequality in our world: poverty, illiteracy and ill-health. However, so far progress towards the health MDGs has been worryingly slow, lagging behind other areas such as education and poverty reduction. Less than one-in-five poor countries is on track to reach the under-five mortality goal of a two-thirds reduction between 1990 and 2015. More than 500,000 women die each year due to complications during pregnancy and, of the over 10 million deaths each year among children under five, about half are due to preventable and treatable diseases. The HIV/AIDS pandemic continues to represent a huge burden, and is by far the leading cause of premature mortality in sub-Saharan Africa.

Concerned with the lack of progress, representatives from several development agencies, including the World Health Organization and the World Bank, met in Ottawa in May 2003 to discuss what can be done to improve health outcomes in developing countries. They recognized that challenges were matched with opportunities: the potential for an extraordinary expansion of international funding for health, the emergence of new actors, such as global health partnerships, and greater political attention to certain aspects of health, in particular communicable diseases.

Participants at Ottawa agreed an unconventional approach to address challenges and harness opportunities – a series of informal meetings of high-level representatives from development agencies and governments, acting on their own behalf and limited in number to promote candid and focused discussion of constraints to progress on the health MDGs and possible ways forward.

The first meeting of the **High Level Forum on the Health MDGs** (HLF) took place in January 2004 and brought together ministers of health and finance from developing countries, bilateral and multi-lateral agencies, private foundations, regional organizations and global health partnerships. A

further two meetings of the Forum were held, in Abuja in December 2004 and a year later in Paris in November 2005.

The Forum was designed as an opportunity for senior officials to increase their understanding of global health issues and to build a consensus on ways to accelerate progress. To encourage open discussion, the Forum was deliberately designed to be informal, limited in size, flexible, off-the-record and temporary. Over time, six principal themes emerged:

- **Scaling up** resources for health
- Increasing the effectiveness of aid for health, improving harmonization and alignment across different initiatives including **global health partnerships**
- Increasing **fiscal space** for health and managing the macroeconomic effects of scaling up health spending
- Improving national and global capacities to **measure and monitor** progress towards the MDG targets to evaluate the impact of increased flows of resources on health outcomes.
- Addressing the crisis in **human resources for health** in low-income countries
- The special circumstances surrounding health delivery systems in ‘**fragile states**’.

To accompany the discussions at the Forum, background research was commissioned by the Secretariat in each of these areas.

This publication brings together a selection of papers and as such represents an overview of the analysis and work undertaken throughout the life of the High Level Forum. For further reading, additional supporting papers and presentations made to the High Level Forum are available on the HLF website [www.hlfhealthmdgs.org](http://www.hlfhealthmdgs.org)

In early 2006 independent evaluators undertook a review of the High Level Forum and identified its key outcomes to date.

- The HLF provided a mechanism to translate the intentions of the Paris Declaration on Aid

Effectiveness into tangible guidance for global health partnerships, resulting in a set of 'best practices for global health partnerships'. These principles have now been adopted by the boards of Global Alliance for Vaccines and Immunization (GAVI), the Health Metrics Network and the Stop TB Partnership, and are currently being considered by others.

- Gave exposure and support to the fledgling Health Metrics Network. As a result, the importance of strengthening health information systems is now widely recognized by key actors.
- Expanded debates on fiscal space to include the special needs of the health sector, and created an opportunity for dialogue between health ministers, finance ministers and the IMF.
- Deepened understanding of how donors can support the health sector in "fragile states". HLF papers have fed into work at the OECD/DAC in this area.
- Finally, the continued focus by the HLF on the crisis in human resources for health played a

major role in raising awareness of the issue.

Both developing countries and bilateral agencies now recognize the need to develop new strategies and increase resources to address this crisis. Following on from the momentum created by HLF discussions, the Global Health Workforce Alliance has now been launched with the strong support of bilateral partners.

The series of three meetings of the High Level Forum has been completed but work in each of the key policy areas continues, and initiatives are now underway to translate the achievements of the HLF into action at the country level. In particular the World Health Organization and the World Bank continue to collaborate in seeking new mechanisms to: influence the policy and practice of health development partners; improve technical support provided to countries to integrate health into poverty reduction strategies and accompanying budgets; and, explore new financing instruments for countries receiving limited donor support.

# INTRODUCTION TO THE PAPERS

This publication brings together a selection of papers that were commissioned by and presented to the High Level Forum. It represents an overview of the analysis and work undertaken throughout the life of the High Level Forum on the key policy areas of concern to the health sector.

## Scaling up Aid for Health

Three papers are concerned with the overall questions surrounding the scaling up of aid and efforts to increase its effectiveness. The first, “*Resources, Aid Effectiveness and Harmonization*” which was prepared for the first meeting of the HLF outlines the key issues, challenges and prospects for scaling up aid to health and how best the various initiatives and efforts can be harmonized to enhance their effectiveness. It grapples with the on-going debate surrounding how much additional aid is needed and the potential role of Poverty Reduction Strategy Papers in this context. The paper also touches on the new actors and instruments emerging in the health field and the impact of increasing aid flows on economic stability.

The second paper on this subject “*Harmonization and MDGs: A Perspective from Tanzania and Uganda*” looks specifically at the increased harmonization efforts at the national level. The paper was also prepared for the first meeting of the HLF and it presents a detailed analysis of the way in which health indicators in Tanzania and Uganda have been affected by shifting aid policies and practices, both by the national government and by donor behaviour. The paper looks closely at the impact upon the national economies and asks what bottlenecks remain that can impede the achievement of the health MDGs in these countries.

The third paper in this area, “*MDG-Oriented Sector and Poverty Reduction Strategies: Lessons from Experience in Health*” was prepared for the second meeting of the HLF and is concerned specifically with the role of Poverty Reduction Strategies in helping countries to meet their health MDGs. It

draws on research in a wide range of countries across several continents and raises key questions surrounding the development of macro-fiscal frameworks and absorptive capacity.

## Fiscal Space and Financial Sustainability

The lack of predictability in aid flows was highlighted as a key problem for developing countries that are aid-dependent. Aid flows are estimated to be up to seven times more volatile than domestic fiscal revenue. New mechanism are urgently needed that can promote predictability while increasing support to the national budget for the health sector within the context of overall development priorities, poverty reduction strategies and medium-term expenditure frameworks. Two papers deal specifically with the question of the fiscal space available to national governments and how this impacts upon their long-term policy decisions. Both papers were prepared for the final meeting of the HLF. The first paper in this series, “*Fiscal Space and Sustainability from the Perspective of the Health Sector*” provides a definition of fiscal space and examines what sustainability implies. Various scenarios of changes in donor and government policies are explored and developed together with projects of their impact on health spending. The paper considers in depth trends in both donor and recipient government behaviour as well as the likely macro-economic effects of scaling up.

The second paper in this series “*Fiscal Space and Sustainability: Towards a Solution for the Health Sector*” seeks to identify the key budget management issues that need to be addressed in order to plan and implement a scaling up of the health sector financed by additional aid. It maps out the parameters of possible solutions and discusses various initiatives currently being debated.

## Global Health Partnerships

A key outcome of the work of the High Level Forum on harmonization was the development of a series



of best practice principles for guiding the behaviour of Global Health Partnerships (GHPs) at the country level. Building on early work of the HLF on donor harmonization, this area of work looked specifically at activities at the country level of GHPs, such as the Global Fund to fight Aids TB and Malaria and the Global Alliance for Vaccines and Immunization (GAVI) amongst others. It was informed by an assessment undertaken by the Bill & Melinda Gates Foundation and McKinsey & Company which looked at what GHPs could do to reduce the burdens they place on countries and so serve countries more effectively. The assessment, *“Global Health Partnerships: Assessing Country Consequences”* was finalized in November 2005 and presented to the third High Level Forum in Paris; it is included in this volume. It highlighted problems of poor coordination and duplication, the high transaction costs to both donors and recipients, the variable degrees of country ownership and the lack of alignment with national health systems and priorities.

The Gates-McKinsey report was a key contribution to second report presented to the HLF *“Best Practice Principles for Global Health Partnership Activities at the Country Level”*, which provided a synthesis of research into the impact of Global Health Partnerships at country level and, based on this, suggested a set of best practice principles for GHP engagement. These principles attempt to apply the Paris Declaration on Aid Effectiveness agreed under the auspices of the OECD/DAC to the activities of GHPs. Several GHPs are now in the process of debating and in some cases adopting *“Best Practice Principles for Engagement of Global Health Partnerships at Country Level”*.

## Health Systems

Another significant focus for the HLF was the need to improve national and global capacity to measure and monitor health information. In order to do this, health information systems need to be strengthened, better coordinated and more oriented towards country priorities and needs. First and foremost, information systems must provide data for policy-making at national level, but they also need to respond to global demands to monitor progress towards the MDGs. The Health Metrics Network was being developed in parallel to the work of the HLF and has been welcomed as an important initiative in this area. Rather than replicate this innovative work, the HLF chose instead to follow the develop-

ment of the HMN and offer its advice and guidance from the perspective of high level policy makers. The paper included in this volume, *“Monitoring the Health MDGs”* was presented to the HLF by the HMN and outlines the need for health information, the existing gaps and the possible strategies to address these. Since the paper was written the work of the HMN has moved on significantly. An update on its activities is included in an annex to the original paper.

Alongside the need to monitor health information is the parallel need to track the resources flowing to the health sector on both a global and national level. At the first meeting of the HLF members of the Forum recognized the shortcomings in the international community's ability to track financial flows and requested that further work be undertaken to ascertain the feasibility of improving this capacity specifically in the health sector. The Global Health Policy Research Network, a programme of the Center for Global Development was already engaged in this research and presented a paper to the second HLF. *“Tracking Resources for Global Health: Progress Toward a Policy Responsive System”* identifies key links between resource tracking and making progress towards meeting the health Millennium Development Goals (MDGs), lays out the specific ways in which information on resource flows, including data on both commitments and disbursements, can inform policymaking, and indicates the type of information required to each policy use. The paper also highlights major sources of data on resource flows that are currently available, and identifies major gaps relative to policy needs. It also provides a brief summary of the major gaps in the available data, relative to policy needs and identifies a set of key issues that need to be addressed to develop an appropriate strategy to fill these gaps. At the third and final meeting of the HLF in November 2005 an update on progress in this area was provided. The paper entitled *“Following the Money in Global Health”* outlines where further gaps in country and global level reporting and accounting exist and the response so far to address these. It contains a series of four detailed and specific recommendations of ways in which donors and technical agencies can support national governments.

The crisis in human resources within the health sector in low-income countries is well documented but its magnitude has only recently been recognized as requiring urgent attention. It emerged as a significant and consistent area of concern for the HLF.



A series of papers were presented to each of the meetings of the HLF, two of which are included in this volume. The first, “*Improving Health Workforce Performance*” outlines the extent and nature of the crisis. It explains how the crisis has been exacerbated by a reluctance among donors to fund recurrent costs such as salaries and incentives to work in rural areas, deteriorating working conditions within health delivery systems and the on-going migration of health workers from developing countries to the industrialized world. Furthermore, the HIV/AIDS pandemic has also had a devastating impact upon the health workers themselves.

The second paper “*Working Together to Tackle the Crisis in Human Resources for Health*”, presented at the last meeting of the HLF outlines the various initiatives and activities underway at global and national levels that are seeking to turn the crisis around.

### Health in Fragile States

The challenges of reaching the health MDGs are particularly acute in countries that are either unable or unwilling to deliver health services to their populations. Indicators suggest that the populations of these ‘fragile states’ bear a disproportionate burden of disease and mortality. Operating in countries emerging from conflict and political instability as

well as those with poor governance structures presents additional problems of harmonization and alignment among humanitarian, transition and development actors. The HLF believed that the particular context of these ‘fragile states’ warranted closer examination. Two papers are included in this volume that deal specifically with the challenges of scaling up health interventions in fragile states. The first, “*Health in Fragile States: An Overview Note*” outlines the extent of the health challenges in fragile states and the complexity of the operating environment for both humanitarian and development partners. The paper draws on the Principles for good international engagement in fragile states developed by the OECD/DAC in April 2005.

The second paper “*Health Service Delivery in Post-Conflict States*” takes a more detailed look at the post-conflict environment and the array of dilemmas facing decision-makers seeking to deliver effective health services in such a context. It outlines the difficulties as well as the opportunities that frequently emerge in post-conflict situations and the likely nature of the recovering health sectors. The paper includes some recommendations for best practice and highlights some common mistakes to be avoided.

For further reading, additional supporting papers and presentations made to the High Level Forum are available on the HLF website [www.hlfhealthmdgs.org](http://www.hlfhealthmdgs.org)





# RESOURCES, AID EFFECTIVENESS AND HARMONIZATION

By Andrew Cassels, Geneva, January 2004



## I. Introduction

Achieving the health MDGs represents one of the greatest challenges in international development. Not least because they include the goal of reversing the global epidemic of HIV/AIDS. To this we have to add the steep declines required in child and maternal mortality, where progress lags far behind aspirations in many parts of the world. Improving health outcomes will not be possible without major improvements in health delivery systems, which in turn depend on changes in public sector management, new forms of engagement with the private sector, as well as interventions well beyond the health sector itself. Moreover, improvements in health are essential if progress is to be made with the other MDGs, including the reduction of absolute poverty.

This paper briefly outlines some issues in relation to development assistance for the achievement of the health MDGs: how can it be made more effective, how much more is needed, and what has been the effect of trying to harmonize the efforts of different actors?

Increases in the quantum of aid are necessary but not sufficient in isolation: progress will depend equally on policy and institutional change on the part of both donors and governments. Furthermore, the role of development assistance has to be set in the context of changes in national fiscal policies, the domestic policies of donor governments, the management of international debt, and trade policy reforms to increase access to developed country markets.

Beyond the areas of broad consensus, however, lies a critical debate. In essence: should health, and particularly the HIV/AIDS epidemic in some countries – given their potential impact on social and economic development, the magnitude of their financial needs, and the urgent need to prevent a catastrophic situation getting worse – be treated differently from other sectors?

The growing support for global initiatives that aim to provide funding additional to national budg-

etary allocations suggests a positive answer. But others argue strongly that keeping health and AIDS separate from the disciplines imposed by national budgetary systems is not in the long-term interests of the sector.

There is no doubt that global health initiatives will continue to coexist with nationally-led multi-sectoral processes such as Poverty Reduction Strategy Papers (PRSPs). Similarly, donor-financed projects will continue to coexist with budget and sector-wide support. Dealing with the complexity that this entails is a reality. The challenge therefore is to define a strategy that recognizes the need for immediate and urgent action, features progressive institutional capacity development, identifies good examples of harmonization in practice, and looks towards long-term financial sustainability.

## 2. Issues, challenges and prospects

Achieving the health-related MDGs presents special challenges in relation to increasing the effectiveness of development assistance and harmonization. These are presented here in summary form to give a sense of the range of issues that have to be addressed. Selected points are then explored in more detail in the subsequent sections.

- Even allowing for greater efficiency in resource use, there remains a significant gap in resource availability if the health MDGs are to be achieved. But how resource needs should be quantified remains a matter of debate.
- In the absence of concomitant policy and institutional change, both within and beyond the health sector, increases in development assistance alone are unlikely to be sufficient. Developing a consensus on what constitutes effective policy and institutional change across the full range of health MDGs will be a key component of a vision of how they can be achieved.
- Countries that implement reforms – the good performers – are likely to attract additional resources. At the same time, a vision for achieving

the health MDGs has to make provision for the many millions of people that live in countries with poor policy environments, or where states in crisis – for whatever reason – are unable to fulfill basic functions.

- Health spending – even spending on primary care – does not automatically benefit poor people, and the measures used to assess progress against the MDG targets are based on national aggregates. A further element of the vision is therefore to ensure that health policies, health systems and the aid instruments that support them are designed both to maximize the impact of better health in poverty reduction, and to address the needs of poor people.
- There is growing support for aligning external assistance around national poverty reduction strategies. The preparation of PRSPs may draw on sectoral strategies where they exist. The greater challenge is to ensure that the poverty analysis which informs the PRSP also influences the orientation and focus of work in the health sector. In addition, there is a need to be clearer about how national AIDS strategies – which are themselves multisectoral – can most productively relate to the PRSP process.
- The focus of much of the drive towards harmonization is primarily on how donors can better support public policies. In many low income countries, however, a large share of health financing and provision originates in the private sector. This creates further challenges for achieving harmonization, and highlights the need to broaden the agenda so that it includes ways in which governments can build networks with civil society, NGO groups and private business.

The search for new resources, and the need to attract new donors, has led to the creation of new aid instruments, such as The Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Finance Facility and the Millennium Challenge Account. The key challenge is to attract funds that are genuinely additional, and to ensure accountability that will satisfy new financiers, without creating greater demands on thinly stretched administrative systems.

The availability of additional, earmarked grant funds for health – from mechanisms such as the Global Fund – can and has led to tensions between financial ceilings set by ministries of finance aiming to maintain macroeconomic stability on the one hand, and the need to expand the resource envelope in the health sector on the other.

- It is widely accepted that there is a role for different types of aid delivery instruments. While many donors are moving towards providing assistance as budget and sector-wide support, a significant amount of external assistance in health still comes in the form of project funding. If projects have a clear purpose and are aligned with national strategies, they can fulfill an important role in terms of innovation, capacity-building and policy experimentation. However, when the proportion of off-budget finance increases, the risks also increase. In part, this is due to transaction costs – particularly as a result of separate reporting requirements – but more fundamentally it exempts a large part of in-country spending from democratic scrutiny.
- Only by working to scale can the health MDGs be achieved. The challenge facing national authorities is to deliver on priority outcomes, while building effective systems capable of addressing multiple health conditions. This is particularly difficult when agencies compete for scarce human resources to fund specific programmes.
- Both development agencies and governments recognize the importance of increasing the predictability of aid, but at the same time there is a growing trend to link disbursements to improved performance, particularly in the period between the tranches of assistance. Intermediate indicators must necessarily be clearly linked to health impact and outcome, and there must be consensus on the benchmarks which will be used to demonstrate progress or lack thereof.

From this list of issues it is evident that improving effectiveness and increasing harmonization has many dimensions – affecting all stages of the programme cycle, from analysis, through implementation to monitoring and evaluation. However, while the list of challenges is long, there are a growing number of examples, cited in the text which follows where development assistance has been made more effective and there have been positive benefits as a result of greater harmonization<sup>1</sup>. Even if existing instruments are imperfect, improvements are clearly possible.

While the focus of this paper is primarily on what happens in relation to harmonization at country level, this can be enhanced by enabling actions at a global level such as through agreements affecting access to life-saving drugs through the interpretation of TRIPS in the Doha Declaration on Public Health.

### 3. Analysis and strategy development: estimating costs and mobilizing resources

Current levels of health spending in most low-income countries are insufficient for the achievement of the health MDGs. The question is raised, however, as to how much is needed. This section argues that estimates of resource needs should focus on the country level, but recognizes that there are differences in opinion as to how these should be calculated.

The Commission on Macroeconomics and Health (CMH) suggested that countries could increase the allocation of domestic budget resources for health by an additional 1% of GNP by 2007. Evidence suggests that while there is some upward movement in health spending, it is rarely of this magnitude.

Even if countries were able to act on the CMH recommendations, there would still be a substantial shortfall that would have to be met primarily from increases in development assistance.

In order to achieve the MDGs as a whole, it has been suggested (for example in the Monterrey Consensus) that an additional US\$ 50 billion of development assistance is needed each year. If commitments made by G8 members are realized, aid to Africa would double by 2010 resulting in significant new resources for the health sector and to date, development assistance to the health sector has seen some modest progress. As well as an overall increase in the percentage of total aid over the last decade, annual commitments have increased from US\$ 6.4 billion on average between 1997-1999 to US\$ 8.1 billion in 2002 – with much of the increase attributable to commitments to the Global Fund, and to HIV/AIDS more generally. However, the CMH report recommends that annual assistance to the health sector should be increased to US\$ 27 billion by 2007 and to US\$ 38 billion by 2015.

Nevertheless, the question remains as to whether more accurate estimates of need will actually help turn commitments into action. While there may be a case for costing what will be needed to achieve very specific targets, it is questionable whether there is much political mileage to be gained by estimating, and publicizing, another global headline figure for the health MDGs.

Efforts might be better directed towards looking at resource needs in individual countries. Here, however, differences in approach have emerged with important policy implications.

Oversimplifying for the sake of brevity:

- One view is based on the costs of scaling-up interventions, and the systems needed to deliver

them, to meet the various MDG targets. This approach, which results in higher estimates, is based on two important assumptions. First, that the additional funds can be readily absorbed and efficiently utilized (and therefore that the poorest countries need, and can use, the most resources), and secondly, that the various interventions act relatively independently from each other, and from the feedback effect of economic growth. This approach does not preclude addressing some systemic constraints such as salary increases.

- An alternative approach starts from current resource availability, and is predicated on the interplay between improved policies, systems, governance and increments in aid.

Where the first approach looks at the 2015 targets and works back to the money that is needed now, the latter starts with an analysis of current constraints and looks at how to progressively relax them, thereby increasing the quantum and effectiveness of spending. This approach attempts to avoid the problem of two competing scenarios by allowing governments to manage current realities while aspiring to better performance and increased income.

### 4. Analysis and strategy development: health and PRSPs

The debate about how to estimate resource needs raises questions about the purpose of PRSPs. In effect, those that would encourage countries not to shy away from ambition and base their strategies on “real” costs would use the PRSP as an advocacy tool. The alternative approach based on a different interpretation of “realism” encourages countries to focus on more immediate projections of resource availability. The middle way is to encourage countries – as part of the PRSP process – to prepare a set of alternative medium-term scenarios with different patterns of aid, systems development and policy reform. The PRSP in Rwanda, for example, takes this form.

While it is tempting to focus exclusively on the financial impact of PRSPs, it is equally important to examine their influence in other ways. To what extent do PRSPs fulfill their potential as a way of improving health policies, governance and institutions? This in turn will affect how health is treated in Medium Term Expenditure Frameworks (MTEFs) and national budgets – and thus resource allocation and the effectiveness of spending in the sector.



Potentially, PRSPs are important instruments for the health sector:

- As responsibility for the overall PRSP is based in either the ministry of planning or finance, the PRSP process can help illustrate the importance of health to poverty reduction, and thus strengthen the case for increased investment.
- By bringing a poverty reduction lens to the health sector, PRSPs can catalyse a more pro-poor analysis of health challenges, and prompt an examination of why existing policies fail to reach vulnerable groups.
- The process thus offers an opportunity to reorientate national health plans and strategies to those health actions most likely to impact on poverty and the needs of the poor.

The real potential of PRSPs is becoming evident in some countries. In Uganda, the process helped ensure a reorientation of the health policy towards the needs of the poor. In Mauritania, the PRSP profoundly changed the approach to delivering services for poor people – and was in addition successful in dramatically raising health spending.

However, analysis suggests that these are the exceptions rather than the rule and too often PRSPs do not fully deliver on their potential to influence change. For the most part, PRSPs appear to draw on existing national health strategies, without examining their effectiveness or their ability to reach the poor. In addition, while paying lip service to links with the MDGs, few PRSPs capitalize on the opportunity presented by a cross-sectoral planning process to promote the achievement of health and human development outcomes through non-human development inputs such as transport, fiscal policy (e.g. tobacco taxes) and household energy. Instead, PRSPs tend to rely on the delivery of traditional health services, providing few pointers to the most essential areas of policy and institutional reform needed to achieve the MDGs.

In conclusion, PRSPs are an important entry point for tackling poverty/health challenges in low-income countries. However, PRSPs alone are not sufficient as a means of creating capacity or commitment to poverty issues in ministries of health. Greater support from health and development partners, links with other processes, defining key policy and institutional changes to increase effectiveness, and continuing advocacy with higher levels of government, remain essential to achieve this end.

## 5. Implementation challenges: new actors, new instruments

A wide range of strategies have been proposed for raising additional resources for the achievement of the MDGs. Most current strategies have two targets in common: non-traditional donors, particularly from the private sector; and those OECD countries that are furthest from providing 0.7% of GNP as development assistance.

While there is no question that new resources are needed, the means by which they are managed and disbursed are equally important. Inevitably, there is a need to manage tensions that emerge between the desire to reduce transaction costs and support national policies on the one hand, and some of the demands of new actors and new systems on the other.

- Private foundations – such as the Bill and Melinda Gates Foundation – have become major financiers of health and development on a par in terms of volume of aid with both the larger bilateral donors and development banks while at the same time seeking a more distinct identity in terms of approach.
- The corporate sector, despite its increasing involvement, has yet to find a fully settled role outside of its own sphere of operations. Part of the thinking behind mechanisms like the Global Fund was to provide a corporate-like environment for tackling priority health problems that provided a common and secure channel for investors lacking a country presence. However corporate involvement in the fund, as a significant donor, has been limited. Inevitably, this raises questions about whether common funding channels such as the Global Fund provide companies with sufficient visibility, or whether the corporate sector's role lies more in individual companies providing support through the provision of goods and services in kind.
- The International Finance Facility (IFF) currently being piloted in immunization, involves the private sector in a completely different way. Long-term commitments from traditional governmental donors will be used to leverage immediate and additional resources for aid by issuing bonds in the international capital markets, thereby enabling the front-loading of aid. While the IFF sets its sights clearly on increasing aid before 2015, one can anticipate that needs will continue after this date.



- Although the United States Government has been a strong supporter of common mechanisms such as the Global Fund, a larger proportion of its development assistance is managed through new and existing bilateral mechanisms such as the Millennium Challenge Account and the President's Emergency Plan for AIDS Relief. Three features of these mechanisms stand out: a highly selective focus on countries with specified policy environments; strict accountability requirements; and a refusal to support organizations that pursue activities contrary to domestic political positions (such as support for abortion). Although these requirements make it difficult for the US to join in common financing arrangements at national or sector level, the level of resources and political support that has been brought to bear against diseases such as HIV / AIDS and now malaria is nevertheless, of major significance.
- In the space of three years, the Global Fund to Fight AIDS, Tuberculosis and Malaria grew from an idea to an organization that has received pledges totaling over US\$ 8.8 billion. During this time, the Board and Secretariat have had to negotiate many of the tensions inherent in providing aid for health. They include, among many others: providing support for national strategies versus targeted projects; eligibility for all countries or only the poorest; working through governments versus giving more prominence to non-state actors; building national capacity to monitor versus the establishment of parallel systems; supporting locally-owned strategies while trying to shift national priorities towards the three diseases; earmarking funds for priority purposes or regions versus allowing a demand-led system; and so forth.

Four conclusions emerge: (a) that the experience of the Global Fund and the Global Alliance for Vaccines and Immunization (GAVI) shows that raising new resources from non-traditional donors such as the private sector is possible but that governments still provide the bulk of resources raised; (b) that other new approaches such as the IFF and airline tax could bring significant additional resources; (c) that plurality of channels and systems would seem to be an inevitable consequence of such initiatives in the short term; and (d) that there is a tendency for the new philanthropic donors to focus on specific diseases and health conditions and to shy away from systems strengthening per se.

## 6. Implementation challenges: increasing resources and economic health

One of the many effects of the establishment of the Global Fund is an increase in the overall quantum of grant resources available to health. In several countries, this has given a new edge to the long-standing debate about the impact – real or potential – of increases in aid on macroeconomic stability. In considering this matter it is useful to separate arguments over sovereignty from those of economics.

The economic argument centres on what constitutes financial sustainability. Some have made the case that increases in aid, depending on what it is used for, can influence exchange rates and export competitiveness and thereby, economic growth. Individual economists disagree on the seriousness of these issues in different contexts, and the extent to which they should act as a brake on external assistance.

However, in countries faced with a serious disease burden, failing to address major causes of ill-health will hit economies considerably harder and potentially for a longer period of time. For these countries, fiscal policy should therefore be considered and defined within a context in which the death of teachers, police and health workers is occurring at a rate faster than the state can replace them.

The sovereignty issue is perhaps more difficult. Ministries of finance have to balance competing demands and to make judgements about the relative contribution of many sectors to poverty reduction. They are accountable for achieving economic growth targets and, in a resource scarce environment, are obliged to set spending limits. The question is therefore: who should have the final say when a donor – such as the Global Fund – insists that their earmarked funds be additional to previously agreed spending limits?

The issue of fiscal discipline, manifest in the form of resource ceilings, raises its head in other ways – particularly in relation to public sector employment. A significant increase in development assistance for, say, AIDS treatment or child health, will have limited impact if there are insufficient health workers available for health centres and clinics. At the same time, there is no doubt that many countries have wrestled for years with the inefficiencies that occur when staff salaries squeeze out all other forms of operating expenditure. Staff take time to train, and there is thus a lead time before national authorities can respond to new financial circumstances. Most will want to be reassured that

these new levels of assistance will be sustained to allow for the long term employment of newly trained workers.

## **7. Implementation challenges: defining a role for project spending**

A growing number of donors provide an increasing proportion of their assistance as budget support. If the PRSP and MTEF are agreed by all concerned, then financing directly through the national treasury is an obvious next step.

At the same time, evidence indicates that in the health sector, one can expect that a significant proportion of aid will still come in the form of projects. It is also the case that relatively few countries are running SWAps that genuinely cover all forms of sectoral spending. Many of the reasons for this are related to the requirements of different donors and have been touched on in previous sections. In addition, several governments regard some aspects of health spending as not being up for negotiation or scrutiny by outside agencies. The question to ask then is does this matter, and are there any reasons that actually argue in favour of projects?

Many argue strongly that the achievement of health goals requires working through civil society and grass-roots organizations. Groups at risk of HIV or TB that live on the margins of society are often best reached by other groups that also operate outside society's mainstream. Channeling funds to such groups through governments can be problematic, particularly while trying to work to scale and maintain consistent quality standards – even if these groups have the capacity to absorb more resources.

Health sector plans and budgets often perpetuate historical patterns of spending. They rarely contain adequate provision for systems building or innovation. How many national budgets in Africa or Asia, for instance, made provision for spending on AIDS, let alone AIDS treatment? While the Global Fund is keen to be seen as a supporter of PRSPs and SWAps, it also has a major role as a source of innovation and capacity-building.

Clearly there is a role for project spending – particularly in policy experimentation. Problems arise when off-budget spending increases excessively in volume, when it is used to divert genuine national priorities, when it generates disproportionate costs in terms of management time, and – most critically – when it is used in the absence of some overall sectoral strategy that has been subject to some form of democratic process. The form that such a strategy

should take – as noted in the section on PRSPs – requires further exploration. Some argue that if development assistance operates increasingly at an overall budget level sectoral support will not be necessary. An alternative approach is to seek a closer match between the needs of particular countries and the balance of aid instruments used.

## **8. Implementation challenges: managing multiple partners**

At the heart of the harmonization agenda is the way that development partners interact with national authorities. Several aspects of this relationship – particularly alignment around national priorities as reflected in the PRSP and MTEF – have been touched on. There are, however, several other practical aspects of harmonization: the 'nuts and bolts' issues that make all the difference in reducing transaction costs.

They include: shared analytic and sector work; joint review missions; common financial management standards; pooled procurement arrangements; common policies in relation to project management, contracting and payment of technical assistance; and training and staff development. While the focus at country level is often on pooling resources – basket funding – progress can also be made on some of these other issues between a wider group of donors.

While the Rome Declaration focused on harmonizing donors' efforts across a broad front, coordination of national and donor responses is equally important when it comes to issues such as HIV / AIDS. Recent work in this area has identified three principles: one agreed action framework; one national AIDS authority; one country-level monitoring and evaluation system ("three ones" in the jargon). Although a move in this direction is a logical response to competing structures, coordination mechanisms and systems, the challenge is to link AIDS-specific coordination to mainstream harmonization in a way which is mutually reinforcing.

## **9. Monitoring and evaluation: performance and predictability**

Both governments and development agencies are aware of the need to increase the predictability of aid. In the absence of greater certainty about aid flows, governments find it hard to plan, budget and recruit adequate numbers of staff. If AIDS treatment, the continuation of which is essential over a lifetime, becomes dependent on major increases in

development funding, the issue will become even more acute. At the same time, there is a growing tendency to link disbursement with performance and results in order to sustain political support for aid. The experience of GAVI, which relates funding to measures of performance, but also engages in financial sustainability planning, is particularly important in this respect.

Issues related to assessing progress towards achieving the health MDGs has been addressed in one stream of work of the High Level Forum. The challenges around this area of work include reaching agreements on precisely what is going to be monitored, what constitutes satisfactory achievement, and how roles and responsibilities of governments and agencies are to be coordinated.

# HARMONIZATION AND MDGs: A PERSPECTIVE FROM TANZANIA AND UGANDA

By Leo Devillé, with the contribution of Francis Omaswa and Hussein Mwinyi, Geneva, January 2004



## I. Introduction

This paper presents findings from research on the rate and impact of harmonization at the national level. It focuses on two country case studies; Tanzania and Uganda. The paper looks specifically at the effect of increased harmonization in these countries and whether it has led to any tangible improvements. It compares the different preferred modes for the delivery of donor aid and considers what information on health outcomes is currently available to measure performance. The paper also considers the suitability of various tools available for setting national sector targets. The question of resources needed to reach the health MDGs is also raised including costing, availability and the tensions between scaling up resources and macroeconomic stability. Finally, the paper outlines what bottlenecks currently exist to achieve the health MDGs in the countries studied. By way of illustration, the author has included quotations and opinions expressed by those interviewed throughout the course of the research. For reasons of confidentiality these quotations are un-attributed.

## 2. What has been the effect of increased harmonization?

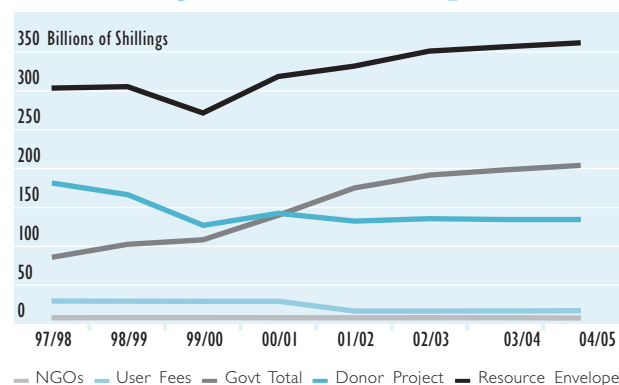
In Uganda and Tanzania, efforts towards greater harmonization through the Sector-Wide Approach (SWAp) as well as a stronger focus on budget support has increased the resources available to the health sector over the past five years. This in turn has led to improved health sector outputs in both countries, but not yet to measurable outcomes in all health millennium development goals (MDGs)<sup>1</sup>.

### Uganda

While the total resources available for the health sector have increased by only 15% in real terms over the past five years, the government budget for health, including budget support, has more than doubled in shilling terms. The allocation to the health sector as a percentage of the total government spending

increased from 7.3% to 9.6% from 2000 to 2003 resulting in general and earmarked budget support for health amounting to US\$ 4.1 per capita. Over a similar period, project aid shrank from about 60% to 36% of total resources for health. The Government abolished user fees in its health units in March 2001. Health units run by nongovernmental organizations (NGOs), however, continue to charge fees and this accounts for 7% of the resource envelope. The shift from project aid to budget support and the concurrent abolition of user fees is illustrated in the graph below.

Resources available to fund Uganda's Health Sector Strategic Plan at 2001/2002 prices



Source: Ministry of Health, Health Sector Performance Report, October 2003.

The increase in the health budget for the period under review has been modest: in absolute terms, only US\$ 1.4 per capita. The Ugandan Government's budget comes from two sources: domestic tax revenues and external aid (both general and earmarked). Because tax collection performance is poor, growth in domestic tax revenues has not kept pace with economic growth. It is increases in donor support, therefore, that have largely funded the increase in the health budget, with a recent trend for some major donors to move away from projects to budget support.

There is also evidence that the increased budget resources have been **allocated more efficiently**. For example, funding for primary health care (PHC)

**Table 1 Some stagnating health indicators in the 1990s in Uganda**

Indicator	1995	2000	PEAP target (2005)	MDG target (2015)
Infant mortality rate (deaths < 1 year per 1000 live births)	81	88	68	41
Maternal mortality rate (deaths per 100 000 live births)	527	505	345	131

and district level services has increased from 32% to 54% of the overall budget, while the central hospital budget decreased from 22% to 12%. They have also been **used more efficiently**, especially in supplying an improved mix of inputs such as staff, drugs and logistics<sup>2</sup>. And they are being **allocated more equitably** through a resource allocation formula introduced in 2003 that includes poverty in its calculations. In addition, the decision to abolish user fees (which has resulted in a sustained increase in outpatient attendance of 72%) has increased access to health services for the poor.

Uganda has sought additional resources for health through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which has pledged US\$ 213 million of which nearly US\$ 80 million has already been disbursed.

The benefits of recent economic growth have been concentrated in certain groups, resulting in rising inequality. The richest 10% of the population have experienced a 20% increase in real consumption since 1997, and the poorest only 8%<sup>3</sup>. The Economic Commission on Africa comments: "There remain vast regional disparities in the incidence of poverty [in Uganda], with a clear spatial pattern. The more affluent central crescent around Lake Victoria has made great strides in economic development, while the drier, more disadvantaged northern part of the country has fallen even further behind. Inequalities in socioeconomic development tend to be linked to inequalities in health<sup>4</sup>." However, the MOH is trying to redress some of those

inequalities by improving its resource allocation formula providing poorer districts with 51% per capita more than Kampala for their PHC budget.

Sector performance provides a mixed picture. From 1995 to 2000, infant and maternal mortality figures stagnated, whereas HIV prevalence rates improved. These statistics differ significantly from those required to achieve the country's own Poverty Eradication Action Plan (PEAP)<sup>5</sup> and MDG targets.

However, since 2000 health sector outputs have improved significantly, reflecting better access to and use of the Minimum Health Care Package by the Ugandan population. A number of PEAP indicators, including the HIV/AIDS MDG and proxy indicators for child mortality MDGs, selected to assess performance of the health sector, have shown marked improvement (see Table 2 below). However, the performance of the indicator for maternal health services remains disappointing.

## Tanzania

Tanzania presents a somewhat similar picture. The health sector's share of the national budget increased from 7.5% in 2000/01 to 8.7% in 2002/03. This is equivalent to a rise from US\$ 3.4 per capita in 1998/99 (US\$ 2.4 from domestic resources plus US\$ 1.0 in donor aid), to US\$ 5.9 spent per capita in 2000/01, to US\$ 6.6 per capita budgeted for 2002/03 (US\$ 3.6 from domestic resources plus US\$ 3.0 in donor aid per capita). Within the SWAp, support for the health sector budget is channelled partly through the President's Office, Regional Administration and

**Table 2 Some improving PEAP indicators**

No.	PEAP performance indicator	Baseline value (99/00)	2000/01	2001/02	2002/03
1	Out-Patient Department utilization (Total Government of Uganda and PNFP)	0.4	0.43	0.60	0.72
2	DPT 3 vaccine coverage (< 1 year)	41%	48%	63%	84%
3	Proportion of approved posts filled with trained health staff	33%	40%	42%	53%
4	Deliveries in health units	25.2%	22.6%	19%	20.3%
5	Urban/rural HIV seroprevalence (national average)	6.8%	6.1%	6.2%	6.2%



Local Government for district support, and partly through the MOH central basket. The UK Department for International Development (DFID), a long-term partner to the SWAp basket, has now moved to general budget support. Although general and earmarked budget support has increased over the past years, off-budget funds (project aid) have remained important. They still contribute 40% of external resources but this is falling.

Overall allocations to the health sector have been increasing in real terms and have become more efficient, with the largest rise being for PHC and preventive services. This signifies a movement in recurrent expenditure away from secondary and tertiary hospitals towards district health services (from 50% to 60% over the period under review) and away from regional administration to local government. It also signifies a reduction in the share of salary costs from 65% to 50%, while increasing the share of “Other Charges”<sup>6</sup>, which is considered a priority in the Poverty Reduction Strategy Paper (PRSP). Both domestic and donor resources have increased<sup>7</sup>, but the main source of extra funds was the Tanzanian Government’s grants to district councils. Foreign aid was 53% and 56% of the total health sector budget respectively in 1999/2000 and 2001/02. The recently adopted resource allocation formula, which includes poverty and under-five mortality criteria, has allowed resources to be allocated more equitably since 2003/04.

Additional resources are sought through different channels. The Global Fund has pledged US\$ 206 million over the full budget lifetime of which US\$ 82 million has already been disbursed<sup>8</sup>.

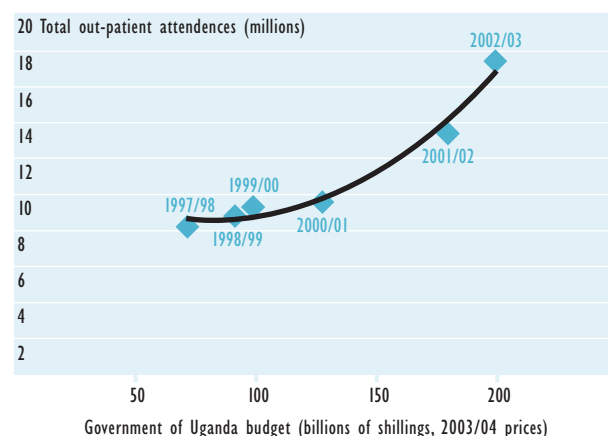
In terms of health sector performance, outpatient attendance has been maintained at 0.9 visits per capita a year. Coverage of the diphtheria-pertussis-tetanus vaccine DPT<sub>3</sub> has increased to 83% and the proportion of fully immunized children below the age of two has increased from 74% to 79%. The proportion of births attended by trained personnel increased from 50% to 80%. The Integrated Management of Childhood Illness and Roll Back Malaria strategies have been introduced and coverage progressively extended<sup>9</sup>. Health-financing strategies such as the Social Insurance and Community Health Funds have been rolled out further and policies on user charges have been maintained. According to the MOH, the introduction of financing strategies has improved the accessibility of quality services, because drugs are now available at all times. There is no recent evidence on whether progress towards the health MDGs is “on track”.

### 3. Has increased harmonization led to any tangible improvements?

Different ways of doing business together by governments and their development partners have resulted in many positive changes, but this depends very much on local leadership. This perception is very much the same in Tanzania and Uganda, among government and other stakeholders.

Tangible improvements in output have been documented (see section 2). Improvements in outcome (as measured by the MDG targets) need more time to materialize and may need focused cross-sectoral interventions (to address, for example, maternal mortality, child mortality, malaria prevalence) as well as broader socioeconomic development (to address child mortality, for example). SWAp and other harmonization efforts have improved efficiency and equity in resource allocation, as illustrated in section 2. It is unlikely that the increase in outpatient attendance in Uganda that resulted from abolishing fees would have been sustained if the supply side had not injected more resources (increased drug supplies; ring fencing of district drug budgets; employment of 2700 additional health workers, etc.). This was made possible by increased budget support (both general and earmarked). New approaches to resource allocation between districts, based on poverty criteria, are another concrete example of governments and partners working together in Tanzania and Uganda. Sector plans have improved. The resources available and the way they are allocated to sector priorities are more widely understood. Ministries of health have become more vocal and knowledgeable in defending their sector budget to ministries of finance, through prioritized sector

#### Government funding and outputs: improving performance in the Ugandan health sector



Source: MoH, Three Years of Implementation of the Uganda Health Sector Strategic Plan, Flyer 2003.

plans, Medium-Term Expenditure Frameworks, Public Expenditure Reports and PRSPs. This new way of doing business together is much appreciated by both governments and development partners.

While most people agree that significant improvements have been made, major stakeholders say that policy dialogue should be more cross-sectoral and more oriented towards results.

#### 4. What is the preferred mode for donor aid?

Governments (ministries of health, ministries of finance) in both Uganda and Tanzania strongly prefer budget support to project aid because it makes critical resources more available for the nationally defined priorities in poverty reduction. Moreover, budget support is more flexible, more equitable and can be decentralized to the level where the needs are greatest and the action must be taken. UN organizations and most development partners (e.g. DFID, the Danish International Development Agency (Danida), World Bank) agree that budget support has added value. However, some bilateral donors, while they support overall national policy directions, maintain project support for other reasons. For example, in 2003 USAID provided just under US\$ 42 million to Uganda for health-related activities, financed entirely as project support. All projects are said to follow the principles and priorities of the PEAP and the Health Sector Strategic Plan (HSSP). USAID has stringent internal reporting requirements which make it difficult for the agency to provide basket funding, but staff also expressed the view that budget support is “inefficient” and lacks transparency.

The methods of budget support differ between Uganda (mainly general budget support) and Tanzania (mainly sector-specific budget support, but now also partly general budget support). However, health sector budgets have increased significantly in both countries. Most stakeholders who favour budget support propose that about 80-90% of donor aid should be channelled in this way. The remainder should be “projectized” with the specific aim of sustaining and guiding the implementation of national health sector plans: developing sector strategies, ensuring that resources are used in the most cost-effective way, testing innovative strategies, covering specific expertise, supporting change. UN organizations (UNICEF, WHO and UNDP) see it as their specific mandate to provide this projectized support, given their technical know-how and expertise. Some bilateral agencies that contribute to SWaPs and

budget support (e.g. Danida, DFID) also want to continue financing specific technical or strategic support through earmarked funding. The partnership fund in Uganda has been used for this. Danida in Tanzania, in addition to supporting the health sector budget, provides earmarked support to, for example, the Health Sector Reform Secretariat. Projectized support to selected central-level activities or units may also help build the capacity to support district services.

Uganda has a Poverty Action Fund (PAF) tool, in place across all priority sectors, which defines the priority budget lines that fall under the PAF in each sector. For health, these are district PHC, district hospitals, NGO hospitals and selected central budget items coordinated by National Service Delivery, such as drugs. This tool helps to prioritize poverty alleviation and MDG goals within the budget and ensures that aid is channelled to those priorities. In Tanzania, the MOH remains somewhat reluctant to move from sector budget to general budget support, because it fears that its budget may be reduced if the Ministry of Finance (MOF) does not give it sufficient priority. The MOH in Uganda, which favours general budget support, is concerned that negotiations with the Ministry of Finance, Planning and Economic Development (MFPED) are failing to deliver the appropriate budget shares intended by the donors.

While most observers agree that increased budget support has improved some outputs, national policy dialogue and the implementation of reforms should be more oriented towards results. In Tanzania, the SWaP has focused mainly on systems building, policy development and process. As the MOH in Tanzania put it: “We have to move from a reform phase to a service implementation phase.” In Uganda, the SWaP is the coordinating mechanism for delivering the minimum health care package and is seen as part of wider health systems reforms. In general, both countries state that health system development is needed but insufficient. A targeted, prioritized and multisectoral approach is required to achieve specific results.

Other forms of aid relate to global initiatives. Both Tanzania and Uganda (ministries of health, ministries of finance and main stakeholders) strongly prefer Global Fund money to be allocated through budget support and to use existing systems, rather than to set up parallel management, accounting and procurement systems. Both countries have effective systems in place. They are trusted and used by major development partners, so it is hoped that over time



GFATM money will be channelled through them. In the case of Uganda, where sector policy is coherent, the MOH argues that budget support facilitates policy coherence. However, the Global Fund remains off budget and several donors continue project support. This suggests that not all development partners and global initiatives accept budget support as the main and most effective financing mode. Project aid also remains a major mode of financing the health sector in Tanzania.

Both Uganda and Tanzania agree that managing all the different flows of funds and a large number of uncoordinated projects remains problematic, but recent trends have been positive. Basket mechanisms and budget support have increased, and projects are better aligned in support of national sector plans<sup>10</sup>.

### 5. Is reliable information on health outcomes available to measure performance?

Both Uganda and Tanzania use specific indicators to measure sector performance. Tanzanian Health Sector Performance Indicators explicitly include all health MDGs, which are also part of the PRSP. District performance is assessed annually by an independent body<sup>11</sup>. However, the reliability of systemic data provided through health management information systems (HMIS) is a major problem. While HMIS can provide facility-based proxy indicators, population-based indicators such as child mortality rate, maternal mortality rate and nutrition can be addressed only through demographic health surveys or a representative sample of sentinel survey sites.

In Uganda, with the exception of malaria and other diseases (TB), all health MDGs are reflected in the PEAP, at least as proxy indicators<sup>12</sup>. Quantitative targets are set nationally and, according to the MFPED, there is a need to scale down quantitative targets to more “achievable” levels. The Annual Health Sector Performance report presents information on all health MDGs. District performance is monitored annually through District League Tables, which include management and service indicators, including some proxy indicators for selected MDGs (EPI, deliveries, sanitation). Quarterly supervisory visits support district performance. Uganda produces a high quality and comprehensive annual sector performance report which could serve as an example for other countries.

### 6. What is the best tool for setting national sector targets such as MDGs?

There is a general consensus among both government and development partners that health MDGs should not be addressed in isolation from the overall MDGs, or outside of the national macroeconomic planning framework. The main reference for targeting and achieving MDGs, including health MDGs, is the PRSP in Tanzania and the PEAP in Uganda. It is generally understood that PRSPs drive the agenda more than the MDGs, but that MDGs are part of, or “mainstreamed” in, the PRSP and the sector plans.

*“MDGs should be mainstreamed in PRSPs and national sector strategic plans, but local ownership is essential and country plans should be supported rather than global agendas. In other words, how can we support national plans in order to achieve the MDGs and not the other way round?”*

In Tanzania, the PRSP gives the MOF the final say on allocation of resources between sectors. Development partners claim that harmonization efforts have done little to increase domestic resources for the health sector and that, although development partners participate in the discussions, their influence on resource allocation between sectors is limited. On the other hand, the MOF would not like development partners to become too influential.

In Uganda, the PEAP (using the PAF) is an effective mechanism for allocating budget resources to priorities across sectors. It suits the MFPED because it gives the ministry the final word, but it also provides the MOH with a powerful allocation mechanism. For example, of the budget increase in 2003/04, 90% was required to be allocated to the agreed health PAF lines. The PAF tool in Uganda could be an example for other countries embarking on budget support.

According to the MFPED in Uganda, the presence of different PEAP and MDG goals has led to different interpretations of their overall purpose among various stakeholders. While goals overlap (e.g. child mortality), some quantitative targets of MDGs (such as reduction of child mortality by two-thirds in 2015) are more ambitious than those set out in the PEAP, and vice versa. The time horizon is also

different for the two sets of goals. However, MDGs can play a useful role. They have already been embraced by certain sectors such as health, can enrich the list of poverty monitoring indicators and allow international comparisons. The challenge for the next PEAP and HSSP revision is therefore to combine them and make them compatible with all MDGs.

*“Most MDGs are more a political than a technical responsibility. We are just considering these high levels of mortality as something normal. Change will only occur if national political leaders start to take mortality seriously and are willing to do something about it. Uganda has shown that this is possible in the HIV/AIDS crisis.”*

## 7. The costs of reaching the health MDGs

While it may be useful to know that achieving health MDGs in Uganda or Tanzania may cost between US\$ 30 and US\$ 40 per capita a year, any detailed costing of MDGs should take into account local constraints and opportunities and is best done at country level. Costing of health MDGs is complex because it should also take into account the effects of other sector interventions, cross-sectoral impact of HIV/AIDS, etc. Many query the need for detailed disease-specific costing exercises, because they carry the risk of promoting attempts to reach health MDGs in isolation from overall development MDGs.

In Uganda, the MOH estimates that it will need to capture 15% of the national budget if it is to achieve the goals set in Vision 2017. The MOH recosted the HSSP and estimated that it would take US\$ 28 per capita to fund the plan by 2010/11. There is no explicit link between this figure and the MDGs, because the HSSP is more geared towards the PEAP goals (where proxy indicators for the MDGs are integrated). However, the estimated US\$ 28 per capita is close to the first rough estimates by the Millennium Project for reaching the health MDGs in Uganda.

## 8. Can the health MDGs be achieved with the resources currently available?

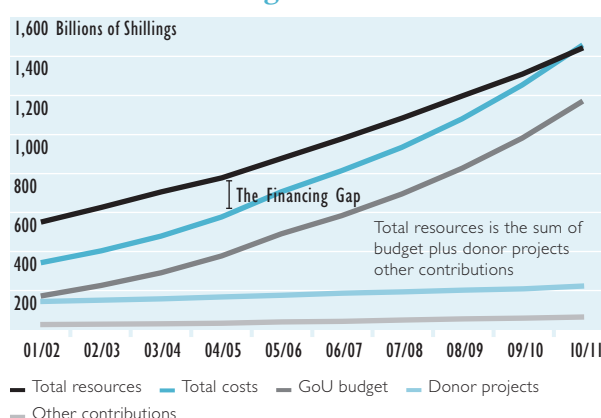
All partners agree that more funds are needed to achieve the goals of sector reform strategies and

health MDGs. Uganda has calculated that it needs about US\$ 28 per capita a year to implement the priority strategies of the HSSP<sup>13</sup>. The increase in resources should be progressive and comprehensive, i.e. it should cover all essential system inputs such as financial and human resources, capacity and skills, and logistics.

As a first step, Tanzania requires US\$ 9.0 per capita (compared to US\$ 6.6 per capita in 2003/04) to implement the first phase of its new strategic health plan. No local cost estimates exist yet for a longer time horizon, but the finances needed in the medium term are likely to be close to those in Uganda.

Both government and development partners agree that scope remains to improve the efficiency of resource use. But most state that increased efficiency may result in only marginal benefits (increased outputs of 10-20%) and not in the significant changes required to reduce maternal and child mortality substantially. To achieve the MDGs, resources must be significantly increased, but this will not be sufficient if it results only in “doing more of what we do now”. To achieve some of the targets, “we have to do things differently and better”. This will involve building health systems, scaling up interventions that have been proved to work, and avoiding the mistakes of the past. To reduce maternal mortality rates, there is a clear need to improve access to emergency obstetric services delivered by technically competent staff. Reducing child and maternal mortality requires well-targeted multisectoral interventions.

## Closing the financing gap for the Ugandan Health Sector Strategic Plan



## 9. How should resources be scaled up if concerns about macroeconomic stability are deemed more important than socio-economic development?

Better health leads to better socioeconomic development but surprisingly, high rates of maternal and

child mortality are now being accepted almost as “normal” at national and global levels. HIV/AIDS and maternal and child mortality are more a political than a health sector responsibility. Politicians should take them seriously and attempt to address them. More resources should be allocated to deal with them. Moreover, communities should be empowered to hold their leaders to account. Uganda is a great example of how HIV/AIDS prevalence has tumbled down, among other reasons because of political support at the highest level and well-targeted actions. But how can resources be scaled up significantly if macroeconomic stability is thought to be incompatible with a larger health budget? According to the MOH of Uganda, this is the **single most important issue** that has to be solved if there is a serious intention to achieve significant progress towards the MDGs.

In Uganda, the MFPED has publicly stated that from 2003/04, budget ceilings will be calculated taking all project aid into account. Although the MFPED has always stated that, for example, Global Fund money would be additional, additionality may be hard to prove. In other words, if the sector accepts more “earmarked” project aid, it will lose out on more flexible budget resources. While the total available to the health sector may remain stable, resources would be earmarked for specific projects which may not be in line with poverty reduction or MDG goals.

The MFPED and some World Bank and International Monetary Fund (IMF) macroeconomists stress that increasing aid can distort exchange rates, undermining export competitiveness and thus, also, economic growth. This is argued in the MFPED’s report on “Uganda’s progress in attaining the PEAP targets in the context of MDGs, May 2003”. The report states that there are three major constraints – resource constraint, absorptive capacity and crowding out of private sector activities. The presence of multiple constraints, it says, implies two trade-offs: between development and macroeconomic objectives, and between the MDG goals themselves. Full implementation of the PEAP would require an increase of 63% in government spending, while achieving the MDGs would be far more expensive. The report acknowledges that social sector interventions boost human resource capabilities through improved health and educational attainment; but it takes time to develop human capital. According to the authors, long-term development objectives may be at odds with short-term macroeconomic objectives, mainly because they crowd out the

tradables sector. Second, sustained efforts to achieve costly sector goals may have macroeconomic and budgetary consequences that make it more difficult to attain other goals, notably a reduction in the number of poor people. According to the authors, the main focus should therefore be on increasing efficiency and effectiveness of current government spending. This viewpoint often prioritizes economic growth above attaining the MDGs or even dismisses the relevance of the MDGs. For example, health officials in Uganda report different World Bank economists as saying: “developing countries like Uganda cannot achieve the MDGs”, and “MDGs are the aspirations of UN agencies which cannot be achieved.”

Not all macroeconomists (including the IMF) agree that this view should prevail. According to an IMF source, “Uganda does not have to refuse aid for health or any other poverty-eradication programmes in order to adhere to IMF-imposed guidelines. . . . Indeed, IMF staff have suggested restructuring public spending so as to accommodate higher expenditures for important social and economic sectors. The amounts of aid and increases in health spending currently under discussion in Uganda would have minimal macroeconomic impact”<sup>14</sup>. There is also a strong argument that increasing expenditure on imported commodities does not harm the macroeconomy.

The same IMF source states: “In the specific case of Uganda, given that the aid flows in question are to be used for top priority spending such as imports of life-saving drugs and other essential medical supplies, we do not see any adverse effects on the macroeconomy. Moreover, even if these aid flows placed pressure on the exchange rate and the competitiveness of the economy, these effects could be minimized through monetary and exchange rate policies.”

As the MOH and many development partners state: “How many more deaths can we just accept for the sake of private sector development or the value of local currency?” and “Is there no way to handle the trade-off between macroeconomic and social objectives in a more flexible way, by allowing progressively more short- to medium-term investment in social sectors, while dealing with the macroeconomic objectives in a longer-term perspective?”

*“Increasing resources for reaching MDGs should focus on increasing local resource availability by reducing or rescheduling*



*debt payments, and by reviewing barriers to fair trade, rather than by only increasing grants and loans.”*

## 10. What are the main bottlenecks in achieving the health MDGs?

- a. For the MOHs of both Uganda and Tanzania, the most important issue is the lack of appropriate levels of **financial resources**, affecting the capacity of the supply side to scale up needed interventions. This affects both the public and private sectors: in Uganda, for example, about 30 to 35% of health services are provided by faith-based NGOs. This means a need for more resources over a longer time. The **unpredictability** of the resources available over the medium term will inhibit governments from introducing any fundamental changes that they cannot sustain (e.g. pay reforms; training and attracting significantly more skilled staff; contracting private sector providers; etc.). Ensuring predictability means a “Memorandum of Agreement for a period of 15 years” and “independent monitoring systems”. The experience of the Global Alliance for Vaccines and Immunization (GAVI) shows how scaling up may be unsustainable if financial support cannot be maintained. Countries may be unable to afford the costly vaccines introduced and paid for under GAVI, after GAVI stops its support<sup>15</sup>.

For Uganda in particular, the **capping of the health sector budget**, with project aid included, in the projected Medium-Term Expenditure Framework is a major constraint to scaling up activities. Project aid in Tanzania continues to be perceived as additional to the budget (including budget support and basket funds), but the MOH faces a similar constraint in convincing the MOF to allocate more budgetary resources to health.

- b. Second (and directly linked with the limited resources) is the problem of **human resources** (both quantitative and qualitative). This is related to issues such as low pay levels, difficulties in retaining staff in public service, brain drain<sup>16</sup>, staff motivation and rewards for performance, pre-service and in-service training<sup>17</sup>, and the impact of HIV/AIDS. Human resource development (HRD) is closely linked with the broader civil service reforms, which tend to lag behind. Tanzania has adopted a more flexible and increasingly decentralized approach to human resource

(HR) management (e.g. District Councils becoming more responsible for HR matters in the near future and defending their case with the Civil Service Department). This seems more effective than the centralized and rather inflexible approach to HR management in Uganda, where all power lies with the Ministry of Public Service (MOPS). For example, Uganda’s MOH cannot introduce allowances for midwives in disadvantaged districts without the agreement of the MOPS. Also in Uganda, the Ministry of Education (MOE) is responsible for training schools, but does not consider them to be a priority. Both Tanzania and Uganda stress the need for more investment in pre-service training, which has been chronically underfunded<sup>18</sup>. In Uganda, because pre-service training of medical staff remains under the MOE, it is not reflected in the PRSP priorities, although long-term sustainability cannot be achieved without appropriate output and quality of pre-service training. Surprisingly, the Tanzanian and Ugandan PRSPs do not address HRD in any systematic way, although both countries agree that HRD is the second most important issue in scaling up service output.

*“If the international community is committed to supporting developing countries in making progress towards reaching the MDGs, it should invest in human resources development (including largely underfunded pre-service training) and be willing to pay part of the human resource cost.”*

- c. Third, efficiency gains can be made when implementing the reforms at district level. In Tanzania, it is claimed that the slow process of **implementing decentralization** through the Ministry of Regional and Local Government has limited improvements in the quality of service delivery. In Uganda, some partners consider the Ministry of Local Government to be a rather weak implementor of the reforms and insufficiently proactive in the health debate. Decentralization, both in Uganda and Tanzania, has yet to achieve more effective service delivery, with participation from local communities and “space” for the voices of the poor to play a part in reducing poverty and attaining MDGs. Effective decentralization

requires the appropriate mechanisms and local capacity for accountability and for monitoring both change as well as the performance of public and private providers.

- d. Lastly, a significant weakness in planning for health MDGs in both Uganda and Tanzania is the **lack of a holistic cross-sectoral view on priority interventions** that improve health. PRSPs remain a juxtaposition of sector priorities and strategies, viewed through individual sector spectacles; they do not take a holistic approach combining, for example, health, education and human resource issues. Health is seen too much as solely a health sector responsibility, and health-related issues that should primarily be addressed by other sectors remain generally underfunded. Competence in multisectoral approaches seems limited, but Uganda provides an interesting example of “best practice”. Following the disappointing child and maternal mortality figures in the 2000 Demographic Health Survey, the MFPED in Uganda set up a task force on infant and maternal mortality which produced its recommendations in 2003. It confirms that activities geared towards reducing mortality should be essentially multisectoral; that inadequate policy implementation, rather than inadequate policies, is an issue; and that mortality reduction will require substantial investment of resources in the social sectors. The task force has identified critical actions to be taken by several sectors. It remains to be seen whether these recommendations will be supported by appropriate levels

of funding in the next PEAP review, given the ceilings set by the MFPED.

*“Take a holistic view to development and poverty rather than focusing on health only. Do not limit health to health sector strategies. Build institutional capacity in multisectoral analysis and implementation.”*

In Uganda, some macroeconomists state that the health sector has no more capacity to scale up, as all systems (public service and NGOs) are stretched to maximum capacity. Increased funding, they say, will lead mainly to increased unit costs, not increased output. This view is not shared by the MOH, which argues that the existing human resources and infrastructure have the capacity to dispense more drugs and supplies immediately. Moreover, there is strong justification for investment in additional capacity to increase coverage to previously underserved populations. This will result in further increases in output without driving up unit costs.

Most development partners agree that substantially more financial resources are needed for health. They need to be introduced progressively and must take into account local absorptive capacity, but their use should be well focused and targeted to cost-effective interventions. However, the need for additional resources must be addressed across sectors, and not for health alone.

# MDG-ORIENTED SECTOR AND POVERTY REDUCTION STRATEGIES: LESSONS FROM EXPERIENCE IN HEALTH

By Mick Foster, Abuja, December 2004



## 1. Introduction

This paper summarizes a forthcoming study to examine how the Millennium Development Goals (MDGs) related to health are being taken forward at country level, based on a literature review plus 14 country case studies of varying depth<sup>1</sup>. The country cases were chosen to include all countries with completed Poverty Reduction Strategy Papers (PRSPs) that were being supported with both an IMF Poverty Reduction and Growth Facility (PRGF) and a World Bank Poverty Reduction Support Credit (PRSC). The paper is organised in eight sections, each with brief 'Summary Points' at the end to highlight the main conclusions and recommendations. The paper first discusses how the health MDGs are reflected in national goals (section 2 and 3), and the content (section 4) and costs (section 5) of the strategies designed to achieve the national health goals. The paper goes on to discuss the resources available for implementing the national strategy, with a focus on the macroeconomic constraints on increasing expenditure (section 6). Implementation issues are discussed in relation to the coordination of health plans with the national budget process (section 7), and a discussion of absorptive capacity problems and what might be done to manage them (section 8). The final section, (section 9), discusses how effectively development assistance is supporting progress towards the MDGs, and what more could be done.

## 2. MDGs and National Targets

All of our country cases make significant reference to the MDGs in setting their own national goals and targets, and many of them set national targets that are consistent with the MDGs. All of them have targets and indicators linked to the MDGs for child or infant mortality, maternal mortality, and improved access to safe drinking water (excepting Albania where near universal access exists and the target relates to household connections). The child and maternal mortality MDGs are clearly regarded as the most challenging, with 9 of our 14 countries

setting a lower target for MMR (Ethiopia having revised down a previous more challenging target), and half of our sample countries setting lower child mortality targets. Conversely, all countries except Ethiopia (which starts from a very low base) have adopted more ambitious water targets, and those few with nutrition targets have also aimed beyond the MDG.

All address communicable diseases although few PRSPs include disease specific targets. There is a wider choice of targets with indicators that reflect local data availability which are not necessarily in line with the MDGs. All except Nicaragua and Tajikistan address HIV / AIDS. Nutrition is universally mentioned, but few countries have specific targets, and the indicators used again depend on local data availability and in some cases differ from the MDGs.

The MDGs do not capture all of the goals to which countries are committed, and are not equally relevant everywhere, with some countries prioritising peace and stability or overall economic growth over an exclusive focus on poverty. The specific health related MDGs also need to be adapted to the circumstances of individual countries: countries may have already achieved one or more of the goals, and may wish to set a more challenging target, as with HIV / AIDS in Uganda or access to clean water in Albania;

- The target reductions from a 1990 baseline may be too challenging to be achievable, especially in circumstances where e.g. child and maternal mortality have stagnated or increased in the 1990s, requiring an even faster rate of reduction to reach the 2015 targets.
- The MDG targets may also be inappropriate as well as too challenging for middle-income countries like Albania where, for example, maternal mortality levels are already relatively low. The MDG target of a three-quarters reduction would imply achieving levels similar to far wealthier countries, and would involve prioritising this specific MDG over other health goals (e.g. reduce

chronic illness) that may be more important nationally.

- The MDGs exclude some health issues that are important in specific countries. For example, smoking in Vietnam, cervical cancer in Nicaragua. A health policy exclusively focused on the MDGs would have significant gaps and inappropriate priorities.
- The MDGs may require disaggregation to address inequality by setting more challenging sub-targets for those population groups and regions with particularly poor health outcomes, as in Vietnam.

#### Summary Points

- MDGs need to be adapted to national circumstances and priorities

### 3. Should strategies be ‘Needs Based’, ‘Resource Constrained’ – or both?

Although there is no formal link with the MDGs, the PRSP has in practice become the main national planning instrument for articulating the strategy for achieving national goals related to the MDGs. The Millennium Project argues that national poverty reduction strategies should be ‘needs based’, setting out strategies that are consistent with reaching the MDGs, and challenging the donor community to fill the financing gap left after reasonable national efforts at resource mobilization. Others stress that, if the PRSP is to be useful as a guide to action, it needs to be linked to the national budget process, setting out clear priorities that are used to guide the preparation of public expenditure plans and budgets based on a realistic assessment of the resources available.

By developing multiple scenarios, some countries (Rwanda, Senegal, Niger) have shown how the PRSP can be used both to guide the allocation of the resources they expect to have, and as a bid for additional support: a ‘high’ scenario is used to attract additional finance by showing what could be achieved with it, while realistic or low case scenarios set out how expenditure plans should be prioritised in the event that fewer resources are available<sup>2</sup>. The World Bank and IMF have supported those countries wishing to adopt this approach, but a strong case can be made for more active encouragement of all countries to do so.

#### Summary Points

- Reconcile ‘needs based’ and ‘resource based’ approaches by developing more than one scenario for PRSPs.

### 4. Framing health strategies to achieve the targets

Most PRSP health strategies are dominated by health services which aim to deliver a package of essential interventions derived from an international consensus on ‘what works.’ There is a focus on promotive and preventive interventions and on primary health care delivery. The strategies prioritise the areas most closely linked to the MDGs, with reproductive and child health and the control of the major communicable diseases given high priority. PRSPs include the costs of expanding education, roads, water and sanitation, and although their contribution to achieving health targets is often recognised, it is seldom quantified<sup>3</sup>.

State funded health systems in many countries are grappling with similar problems: staff availability, pay and motivation, and the difficulty of managing a complex and geographically dispersed service with inadequate financial resources and institutional capacity relative to expectations of what can be delivered. Service coverage is presently low, especially in rural areas, and nearly all PRSPs envisage substantial provision for reducing geographical barriers to access, building new primary facilities, increasing operating budgets, and providing incentives for staff to work in previously underserved areas. However, trends in actual health expenditure are mixed, with no strong evidence as yet of the increases in spending that would be required in order to implement these plans (Table 1).

Decentralisation is a nearly universal theme. It encompasses institutional approaches ranging from ceding responsibility for health services to a lower tier of Government, through contractual arrangements with public and/or private entities to provide agreed levels of service, through to more limited changes to increase the responsibility of lower level units under health ministry authority. This often takes the form of increased authority to manage their own budgets, while holding them more accountable for results, often as part of a wider move to introduce ‘performance based budgeting’ (e.g. Benin, Ghana, Tanzania). The desire to hold those delivering services accountable has not always been accompanied by an equal willingness of finance ministries, health ministries, or donors to relinquish control over expenditure decisions, staffing, and procurement. Reasons of lack of capacity and problems of accountability are cited, but the effect is that good managers may be frustrated in their efforts to achieve improved results (Box 1).



**Table 1 Trends in Public Expenditures on Health**

<b>Albania</b>	Increased health spend as share of budget and GDP since 2001, narrowing gap with Europe with rapid growth performance.
<b>Benin</b>	Committed to increase health budget, but failure to disburse budgeted funds led to a reduced budget share more in line with absorptive capacity. The 2003 and 2004 budgets of roughly 2% of GDP represent 90% of the amounts envisaged in the PRSP, but actual disbursement in 2003 was only 1.5% of GDP – about two thirds of plan.
<b>Burkina Faso</b>	The PRSP envisaged increasing the health budget share from 9.8% in 2000 to 11.5% in 2003, raising per capita health spend from \$7.7 to \$9.5. The MTEF envisaged a health sector share of 7.5% in 2004, increased to 8.5% in the budget due to HIPC funds. Actual spending was just \$5.90 in 2003, 6.3% of budget, due to low HIPC spending. Far from increasing as envisaged, health spending has fallen as a share of budget, GDP, and in real per capita terms.
<b>Cambodia</b>	Government health expenditure doubled from 0.57% of GDP in 1999 to 1.20% of GDP in 2003. Public health spending per capita increased by more than 40% between 2001 and 2003, albeit from a very low base (around \$3 per capita). However, domestic public expenditures represent an estimated 9% of total health sector expenditures.
<b>Ethiopia</b>	Spending fluctuated at around 5% of Government spending since 1992/93, short of the 8.2% targeted in the PRSP for 2004/5. Spending of \$1.50 per capita ranks as possibly the lowest in world. Regional subsidies are forecast to be flat, limiting scope for increase.
<b>Ghana</b>	There has been a 30% real increase in public health spending (Government and donors) since 2001 with the Government spending exceeding 11% target share of recurrent budget. But increases have been dominated by salaries and investment while non-salary recurrent budgets (& productivity indicators) have fallen
<b>Nicaragua</b>	In the period 2001-2003, GDP share increased from 2.2% to 2.95% and the per capita spend increased from \$17 to \$22. Current GDP share is sufficient to meet NDP cost estimates to achieve the goals.
<b>Tajikistan</b>	In the period 2001-2003, spending fell from 1.17% of GDP to 1.01% and from 6.3% to just 5.3% of Government spending – both very low levels.
<b>Tanzania</b>	Health spending increased 75% in real terms in 3 years up to 2004. The budget share of 9.7% is below the Abuja 15% target, spending including donors is only \$7.26, and budget share dropped in 2003-2004 budget. Some increase have occurred in share of primary & preventive.
<b>Uganda</b>	Health share of non-interest budget increased from 2.5% in 1987/88 to 9% in 1998/8 and 12.2% in 2002/3, with improved targeting as the share of the Mother and Child Health Programme (MCHP) has been increased. The target share for 2007/8 is 15% and it is anticipated that current per capita spend of \$8-9 will reach \$11 by 2015 with 15% share. Implementation rate has been over 95%, but fell to 90% in 2003 due to recruitment problems.
<b>Viet Nam</b>	The available data has been limited and partial. However, although trends are unclear, substantial increases in funding of services for the poor do seem to have occurred.

Where decentralisation has been to local Government bodies (Uganda, Tanzania, potentially Nepal), it has in practice been accompanied by earmarking of funds to ensure that national priorities are respected, often accompanied by higher level review of plans and budgets, with incentives and sanctions linked to aspects of performance. Imposition of sanctions is problematic given that the worst performers are commonly the poorest districts where it is hardest to obtain staff, and hence performance budgeting needs careful design to avoid either reinforcing existing inequalities, or lacking credibility because funds cannot be withheld when performance is poor.

Efforts to help communities hold service providers accountable are increasingly common, including community management of primary health facilities (Benin, Burkina Faso, Rwanda, Nepal). An increased community voice is often linked to community financing schemes. Pre-payment schemes increase utilisation by those who are covered, but inability to pay usually excludes the poor from participation (Rwanda coverage ranges from 10-50% of population, Ghana similar). Protecting the poor's access to services by exempting them from payment has proved difficult to implement<sup>4</sup>. Several case study countries are piloting approaches to reduce or eliminate cost barriers to the poor.

## Box 1 Is there a need to delegate more authority to those responsible for achieving results?

**Benin:** 1995 policy envisaged decentralisation to health facilities and districts, public-private partnerships and performance contracts. However, over-centralised budget management has frustrated the policy and prevented planned increases in health expenditure. This is now being addressed with PRSC support.

**Burkina Faso:** Complex multi-level planning, but over-centralised and complex procedures contribute to low budget execution (below 80% including HIPC) and very late release of funds, especially at the periphery. Key MDG priorities are heavily dependent on HIPC funds and donor projects, funds for both of which experience large shortfalls. PRSC is supporting limited introduction of more decentralised access to funds at district level.

**Ethiopia:** Health sector support is inconsistent with block-grant funding of regions. Health SWAP is mainly project financed, but donor projects achieve lower and more variable disbursement than Government funds<sup>5</sup>. Government is pressing for more budget support.

**Ghana:** MOH performance contract with the Ghana Health Service but MOH has retained responsibilities for procurement, staffing and training. There are 23 administrative steps for districts to access GOG funds.

**Nepal:** Reviews in late 1990s concluded vertical projects were inefficient and unsustainable and called for decentralisation and an enhanced community role<sup>6</sup>. Detailed budget programming and late donor confirmation of support results in late releases. But decentralisation is proceeding: sub-health posts are being handed to communities but limited powers at present (eg. no control over hiring staff), but there are plans for local bodies to have powers to vary compensation, plans to devolve drug and medical supply purchase to districts and public-private partnerships are being expanded.

**Tanzania:** District health plans require formal approval by a basket funding committee. This delayed fund release in 2003.

Source: Country Case Studies, WB reports.

Re-allocating budgets, both within and between sectors, is difficult to achieve. Based on the material in our case studies, PRSPs say remarkably little about how non-priority expenditures can be reduced in order to fund expanded services for the poor, with Nicaragua one of the few making explicit reference to increased reliance on the private sector to fund services for the better off. Stated priorities risk being squeezed by growth of other expenditures (e.g. Ghana district services and non-salary recurrent spending have been squeezed by big increases in spending on salaries, on investment, and on central spending; primary health share of total health budget has fallen in Burkina Faso, whereas policy is to increase it).

### Summary Points

- Stronger inter-departmental coordination is needed to move from 'health services strategy' to 'health strategy.'
- Plans for expanding support to high priority interventions (on which there is broad agreement) need to be balanced by plans for how funding can be withdrawn from lower priority services.
- In most countries, achieving national targets requires institutional reforms to strengthen performance incentives, but with accountability for results matched to more reliable access to the necessary resources.

## 5. Estimating the costs of achieving the targets

Health is just one among many sectors competing for scarce funds in order to achieve faster progress towards national goals and the global MDGs. It is important to be explicit about the assumptions linking public expenditure costs to expected health outcomes because the argument for additional resources may otherwise be lost by default, both with the Ministry of Finance, and with the donors. Estimates of the expected costs and impact on outcomes of specific expenditure programmes are also helpful for prioritisation of the budget in the light of available resources, and provide a quantified framework for subsequent monitoring and evaluation and for setting realistic targets for managing performance.

Although some countries have set targets that are less ambitious than the MDGs, all of them have set targets that imply an acceleration of progress relative to the historic trend. Achieving those targets will require increased budgets to fund more challenging expenditure programmes. However, more than half of the case-study countries are spending less than \$10 per capita on health, with Ethiopia spending only \$1.50, Cambodia just \$3. The health sector budget share is in all cases below the 15% target agreed by African countries at Abuja, and in

many the share is both low and not increasing (Ethiopia, Benin, Burkina Faso, Tajikistan, and Tanzania). The resources that are available are in most cases far short of the resources required to achieve the Government goals in the health sector. This risks undermining faith in Government and the motivation of health workers who cannot achieve what is asked of them. Although it does not require sophisticated costing exercises to demonstrate that there is a shortfall, costing the targets can help to make the case for what could be achieved with increased funding. In Mauritania, for example, the 40% increase in the health budget in 2002 was reportedly influenced by analysis suggesting that a targeted increase could achieve a 30% reduction in child mortality and a 40% reduction in maternal mortality within five years<sup>7</sup>.

Although the shortfall in resources has been highlighted in global estimates, it is often obscured at national level by relatively weak analysis. Most poverty reduction strategies do not attempt to estimate the public expenditure cost of achieving their targets<sup>8</sup>. Although most of the health strategies we looked at have been costed, few of them articulate clearly (and provide evidence for) the assumed chain of causality linking the resources required to the activities to be undertaken, the outputs to be produced, and the expected impact on outcomes. Many countries still produce their health budgets on an incremental basis not linked to objectives or even activities (e.g. Tajikistan). Others have moved towards activity-based budgeting in which objectives are stated, but have produced detailed programme budgets in which it is difficult to link the many activities to overall strategic priorities (Ghana, Tanzania). In most cases, the goals are determined with reference to the MDGs and to the expectations of the donors, the plans reflect national constraints and priorities and available resources, but the links between the two are not specified.

A number of different approaches to costing have been developed and are in use for different purposes. There are well established methodologies (supported by good international evidence) for estimating the cost-effectiveness of different health interventions. These provide a sound basis for prioritising the health sector interventions that will be included in essential services packages. Global estimates of the costs of achieving the MDGs have largely been based on estimates of the cost of scaling up the coverage of cost-effective interventions of known efficacy.

For costing national strategies and relating them to outputs, however, an approach is needed that can handle the costs and impact of actions that have wider effects than individual interventions or groups of interventions. In particular, it is necessary to consider the cost and impact of measures to address institutional and incentives problems, and to prepare cost estimates that can be 'mapped' to the way that budgets are actually allocated. One approach that is being piloted aims to do this by packaging interventions in terms of how they are delivered (facility based, outreach, community-based) and focuses on bottlenecks constraining coverage and effectiveness (physical accessibility, human resources, logistics and supply, cost and other barriers to demand and utilisation, gaps in technical and organisational quality, and steering and management costs)<sup>9</sup>. The approach aims to identify those areas where there is most scope for significant impact on health outcomes at modest cost. In Ethiopia, for example, it has been suggested that a 42% reduction in under-5 mortality could be achieved for less than half of the cost required to meet the target reduction of 66%. Although useful as a conceptual approach, the realism of the analysis has yet to be assessed in terms of actual results.

#### Summary Points

- Strategies should include explicit analysis of expected linkages between costs-outputs-outcomes.
- Cost estimates should address institutional constraints and be prepared in a format that can be mapped to budgets and support resource bids.
- Priorities should be identified to permit adjustments in the light of resource availability.

## 6. Are macro-economic frameworks too restrictive?

The level at which public expenditure can be consistent with reasonable macroeconomic stability has been an area of some controversy, and will be discussed in some detail because it is central to the prospects for achieving the MDGs.

A macro-economic framework should contain assumptions on the future growth path of the economy and some justification for the assumed growth rate, informed by past experience and the expected impact of future changes in the economic and policy environment. It should contain a discussion of the future desired level of public expenditure in relation to GDP, and of how it can be financed. The public expenditure projections might start from a 'needs' basis, presenting the costs of achieving

the MDGs or national targets, but may need to modify the level of spending and the national targets in light of the resources expected to be available and the implications for private sector growth and for macro-economic management. The consideration of resources should include a discussion of taxation policy and the expected future share of domestic revenue in GDP. It should consider the past and expected future levels of external grants and loans available to the economy, the terms on which that finance is likely to be available, and the implications for Government debt service. Finally, it should consider the scope for net domestic financing of Government expenditure and develop Government expenditure and financing assumptions that are consistent with a growth in total domestic demand that allows for healthy private sector growth, moderate inflation, sustainable debt burden, and prudent build-up of foreign exchange reserves.

The macro-economic framework may require ceilings to be placed on total Government spending, even if proposed increases in spending are financed by external grants. The problem arises when aid is used to pay for local costs, rather than financing additional foreign exchange costs. In the health sector, local costs are typically 70-75% of total spending<sup>10</sup>. An intuitive way of thinking about the problem is that if donor aid is converted to local currency and used to buy locally produced goods and services, it does nothing in the short term to increase the supply of those goods and services. If there is no spare capacity, the aid-financed increase in Government demand for local staff, construction materials, housing etc will push up their prices and squeeze out private sector demand<sup>11</sup>. This need not matter if the additional outputs produced by the public sector are more socially valuable than the private sector outputs they displace. That may well be the case with cost-effective health expenditures, especially when the positive impact of improved health on productivity is taken into account alongside the social benefits. However, if we assume that the public sector expenditures with the highest benefit: cost ratios are undertaken first, while the least profitable private sector activities are displaced first, there will come a point at which diminishing marginal benefits of additional public expenditure fall below the rising marginal costs of displacing private sector activity. This argument does not depend on assuming that increased donor flows are inflating the real exchange rate and causing loss of competitiveness among producers of traded goods ('Dutch disease.') Irrespective of 'Dutch disease',

in any economy, there will come a point beyond which additional public expenditure on local costs should not be undertaken, even if financed with grants. The argument is not on whether such limits are needed, but concerns the judgment on where they should be set.

Other concerns may also lead countries (and the IMF) to take a cautious line on the extent of dependence on aid. The main requirement for additional spending is to finance incremental salaries and other operating costs of a recurrent nature. Aid is a volatile source of finance. Aid commitments are conditional and short-term whereas the spending obligations are long term and difficult to exit from quickly without provoking political problems. For poor countries such as Tanzania and Ethiopia, simple analysis can demonstrate that sustaining per capita expenditure increases financed by a doubling of aid flows would require the higher level of aid to be maintained for 20 years or more, representing a substantial risk to the Government<sup>12</sup>.

These issues are not discussed in most PRSPs. The IEO evaluation of PRSPs and the PRGF found that only 4 countries from a sample of 10 presented a realistic macro-economic framework, two of them by explicitly adopting the pre-existing IMF PRGF framework, while events conspired to make 4 of the macro-economic frameworks unrealistic by the time of Board discussion<sup>13</sup>. Part of the reason for not developing a robust macro framework within the PRSP may be the recognition that in practice, the macro-economic framework that is actually implemented has to be negotiated with the IMF, since the existence of an on-track IMF programme remains a pre-requisite for accessing significant external aid or HIPC debt relief.

The key criticism frequently leveled against the IMF is that fiscal and macro frameworks have been too pessimistic regarding the resources potentially available, resulting in countries implementing unnecessarily modest public expenditure plans that do not permit rapid enough progress towards the MDGs. At first sight, the empirical evidence appears to suggest that the bias is in the other direction, with IMF programmes over-estimating foreign aid, over-estimating GDP growth, and consequently over-estimating both domestic and foreign resources available to finance public expenditure<sup>14</sup>. IMF policy statements are also supportive of increased aid, stating that additional aid inflows should be accommodated by appropriate adjustments of the programme's fiscal and financing targets, "if they can be effectively absorbed and utilised without endangering macro stability"<sup>15</sup>.



Despite the evidence of over-optimism on aid disbursements, it could still be argued that the IMF may unintentionally restrain future aid commitments by producing fiscal frameworks that assume only modest growth in aid levels. Countries may not push for additional aid flows, nor will donors offer such aid, if the macroeconomic projections on which the expenditure programme is based do not show a clear need for additional aid. **Table 2** shows the assumptions for our sample countries, and does appear to suggest a conservative bias in the projections, all but one of which converge towards a level where public expenditure as a percentage of GDP is around 25%. Only two countries assume more than a 2% increase in GDP share of public expenditure within the projection period, both of them being countries starting from a low base of public expenditure of less than 20% of GDP. With per capita economic growth typically forecast at 3-4% per annum, the projections imply per capita public expenditure increasing by about 50% by 2015. This may sound a lot, but might imply raising Government health expenditure from \$8 per capita to \$12 which is still far short of estimates of the cost of delivering the essential health package to all, and for Ethiopia would leave health spending at little more than \$2 per capita. In a 3 to 7 year projection period, less than half of our sample countries project any increase in net external financing as a share of GDP. Even relatively well performing and low income countries are projecting aid increases for themselves that are well below the commitments made at Monterrey.

It is difficult to assess the fiscal frameworks in IMF programmes, because the Fund provides no clear justification for its assumptions on the level and financing of public expenditure, for which it has been criticized by the IEO<sup>16</sup>. The convergence of spending to roughly 25% of GDP is not a result of IMF policy. It may be coincidence, or it may reflect a tendency for IMF country staff to encourage countries to move towards a level of expenditure that Board and senior management have found acceptable in other cases. Whatever the explanation, the lack of variation between countries in public expenditure assumptions is surprising. Countries differ in their public expenditure needs: low income countries with poor infrastructure and low education and health levels could make a strong case for a higher public expenditure share in order to create the conditions for faster economic growth and poverty reduction<sup>17</sup>. Equally, countries differ in their ability to finance expenditure, both in attracting external

aid and in mobilising domestic resources, without damaging growth and stability. It would also be reasonable to expect that, other things being equal, public expenditure levels would be higher in countries like Uganda and Burkina Faso, where almost all aid flows are recorded in the IMF public expenditure tables, than in countries like Benin, where more than half of aid is not included<sup>18</sup>. The lack of explicit rationale for the assumptions, together with the absence of the expected degree of difference in projected spending between countries, call for a more open debate on the macro framework. Although some aspects of IMF discussions are commercially sensitive (e.g. future exchange and interest rates), there need be no objection to a more open discussion regarding the appropriate fiscal stance, though such discussion is only likely to be fruitful if supported by high quality technical analysis. Uganda and Tanzania both provide striking examples of where the Government has been able to persuade the IMF to accommodate higher expenditure by procuring independent macroeconomic analysis that commanded the respect of IMF staff.

A more fundamental problem is that aid commitments are short-term and unreliable, whereas the additional public expenditure that is needed is mainly for recurring costs that will need to be sustained and to grow into the indefinite future. Even with a rapid increase in domestic revenues, the low-income aid dependent countries that are furthest from the MDGs could only sustain the significant increases in per capita public expenditure required to help them get there if aid donors were able to maintain increased spending levels for 20 years or more. Countries face significant risks if they establish health systems that cannot be maintained in the event of a change in donor preferences.

A range of alternative approaches could be taken to manage this problem: the International Financing Facility as a way to ensure growing aid at least at global level; increased reliance on multilateral channels less subject to political pressures; longer term commitments to specific expenditure programmes, with guarantees that they will continue so long as the programme-specific conditions are met; further debt relief as a form of irrevocable long-term commitment; increased use of aid for reserve build-up to help in managing aid fluctuations. Each of these requires political will on the part of the donors to commit their money on a longer term basis and in ways that are less at risk of interruption in the face of events outside the objectives of the programme itself.

Table 2 IMF Macro-economic frameworks in case study countries

Country	GDP Growth p.a. (geom. average)		Domestic Revenue % GDP		Net External Finance (incl. grants) of Public Expenditure % GDP		Public Expenditure % GDP	
	Historical (years)	Projected (years)	Base (year)	Projected (year)	Base (year)	Projected (year)	Base (Year)	Projected (year)
Albania	6.39% (1999-2003)	6.5% (2003-2007)	22% (2003)	22.4% (2007)	1.7% (2003)	1.9% (2007)	26.5% (2003)	26.6% (2007)
Benin	5.55% (1999-2003)	6.6% (2003-2006)	16.8% (2003)	17.0% (2006)	4.8% (2003)	3.5% (2006)	21% (2003)	22% (2006)
Burkina Faso	6.59% (1999-2003)	5.4% (2003-2006)	12.4% (2003)	14.6% (2006)	8.7% (2003)	5.7% (2006)	21.6% (2003)	23.4% (2006)
Cambodia	5.83% (1999-2003)	4.65% (2003-2009)	10.4% (2003)	14% (2009)	6% (2003)	23.4% (2005) 21.1% (2009)	17.4% (2003)	18.4% (2009)
Ethiopia	3.72% (1999-2003)	6.83% (2003-2006)	19.6% (2003)	20.4% (2006)	14.8% (2003)	8.6% (2006)	29.1% (2001) <sup>19</sup>	29.5% (2006)
Ghana	4.66% (1999-2003)	5.03% (2003-2008)	20.8% (2003)	22.4% (2008)	8.0% (2003)	5.1% (2008)	29% (2003)	24.3% (2008) <sup>20</sup>
Nepal	2.18% (2000-2003)	4.5% (2003-2006)	12.3% (2003)	13.45% (2006)	2.9% (2003)	4.2% (2006)	16.3% (2003)	18.2% (2006)
Nicaragua	2.58% (1999-2003)	4.2% (2003-2008)	21.9% (2003) <sup>21</sup>	22.1% (2008)	10.45% (2003)	8.7% (2004) <sup>22</sup>	30.3% (2003)	28.7% (2004) 26.8% (2008) <sup>23</sup>
Rwanda	5.61% (2000-2003)	5.33% (2003-2006)	13.5% (2003)	13.6% (2006)	10.5% (2003)	17.1% (2004) 13.9% (2006)	24.1% (2003)	28.3% (2004) 25.1% (2006)
Tajikistan	9.47% (1999-2003)	5.85% (2003-2010)	16.8% (2003)	19.1% (2010)	2.8% (2003) <sup>24</sup>	1.2% (2010)	19.0% (2003)	22.1% (2010)
Tanzania	7.58% (1999-2003)	6.06% (2003-2006)	11.4% (2003)	14.0% (2007)	7.7% (2003)	10.7% (2007)	18.6% (2003)	25.4% (2007)
Uganda	5.63% (2000-2003)	5.84% (2003-2008)	12.3% (2003)	13.4% (2005)	11.5% (2003)	8.5% (2005)	23.7% (2003)	22.9% (2005)
Viet Nam	5.43% 1999-2002)	6.8% (2002-2007)	22.5% (2002)	22.2% (2007)	1.4% (2002)	1.6% (2004) <sup>25</sup>	24.8% (2002)	25.1% (2007)

Source: Calculated from data reported in IMF PRGF documents. Nepal, Rwanda and Vietnam numbers are based on 2003 PRGF program. The other countries are based on latest 2004 reported programs.

The plans set out in the PRSP can only be implemented if they are consistent with the macro framework negotiated with the IMF. The PRSP discussions may therefore provide an appropriate forum for the wider debate on the level and financing of public expenditure. Both Ministry of Finance and IMF views need to be reflected in the PRSP. Good practice in this regard includes:

- Ensuring that the relevant staff of the Ministry responsible for preparing the macro-economic framework for the budget are fully involved from the earliest stages in developing the PRSP until the finalisation of the fiscal 'envelope' set out in the approved version;
- The IMF should also be continuously involved through the resident representative, given the requirement for PRGF countries to agree the macro-budget framework with the IMF;
- PRSP priorities and proposed expenditure ceilings should influence and feed in to the preparation of the budget and of any MTEF or medium term expenditure plan;
- The PRSP needs to be a 'living document' that is elaborated as necessary and adapted in the light of events. The institutional details vary, but a number of countries have established systems in which the poverty reduction strategy is annually reviewed, and the results of that review feed in to adjustments to the targets, the macro-economic framework, and the expenditure priorities and budget ceilings.

### Summary Points

- Involve MOF/IMF in preparing PRSP macro-fiscal frameworks to ensure consistency with the budget, but with explicit rationale and more open debate.
- Coordinate annual PRSP progress review with budget cycle including revision of macro-fiscal framework and budget ceilings and priorities.
- Reduce risks of aid dependence by longer term commitments less prone to interruption and more reliable timing of disbursements.

## 7. Coordinating health plans with the MTEF and the Budget

The expenditure implications of the national goals and strategies of the PRSP need to be implemented via the national budget. Examples of good practice include:

- The sectoral priorities of the PRSP and the allocations eventually agreed in the budget are the outcome of an iterative process in which proposals

for sector plans and allocations are prepared by line ministries, scrutinised by the centre, and adjusted in the light of national priorities.

- The PRSP sets out clear priorities and criteria, and those priorities are reflected in the guidelines and ceilings sent to line ministries to guide budget preparation.
- The MTEF that is approved is the same as the annual budget for the first year, and the chart of accounts is structured in such a way that spending priorities of particular importance for achieving the goals can be identified.
- There is an annual process for reviewing sector-level progress, and the domestic and foreign finance requirements for the coming period, timed to feed in to the Government budget preparation cycle.
- There is a central 'challenge' function as part of the budget process, providing credible incentives for line ministries to review their performance, construct well-designed budgets that shift resources towards national goals, and to present them in ways that make the strategic shifts transparent.
- The Ministry of Finance and Cabinet establish and maintain the credibility of the process by ensuring that carefully prepared budgets that are in line with nationally important goals receive favourable treatment in the budget that is finally approved, and in the timely and full release of funds.
- The Ministry of Finance provides credible medium-term assurances of sectoral budget levels or shares, to encourage line ministries to re-allocate resources from lower priority areas without fearing that their budget will suffer as a result. Credibility can be built via a medium-term track record in which it is shown by example that the MTEF guides resources, with year one of each year's budget preparation taking year 2 of the previous MTEF as the starting baseline. Agreements with external partners on the share of spending to be devoted to health are also sometimes used, and can be helpful in reinforcing the confidence of line ministries in their likely future budget share.
- Donor support needs to be fully taken into account in setting expenditure priorities. This requires donor commitments early enough in the budget preparation process, and committed to activities that identified from the national strategy. To minimise transactions costs, aid should increasingly be provided using Government channels to plan, disburse, and account for it.



Many of these good-practice features are present in Albania, Benin, Rwanda, Tanzania and Uganda, although the identification of priority expenditure programmes is in some cases limited to the aggregate level (e.g. sector or sub-sector shares, such as primary health), and only Uganda has a strong central budget ‘challenge’ function. In countries with decentralised budget responsibility, such as Vietnam and Ethiopia, it may be impossible for the Government to establish centrally a medium term framework to determine public expenditure shares. The goal of achieving similar shifts in priority is being addressed through increased resources for targeted national programmes, such as the province-level poverty health funds in Vietnam.

Not all MTEFs have focused sufficiently on achieving a strategic shift in expenditures towards national priorities. The MTEFs in Cambodia and Ghana, and to some extent in Tanzania, are based on detailed bottom-up activity costing, resulting in bulky documents where it is difficult or impossible to see how the changes in the budget allocations relate to higher-level goals and targets.

Where budget preparation and public expenditure management is particularly weak, there may be no effective means to ensure that health strategies are implemented. The effort devoted to preparing a health strategy and a sector MTEF is largely wasted if the annual budget is not implemented in practice and the medium-term priorities are not respected. Several of the countries in our sample still lack any credible mechanism for linking policy priorities to expenditure allocations, with budgets still prepared on an incremental basis, via fragmented parallel processes, and with actual budget execution not reflecting the approved budgets. In Tajikistan, for example, the budget is prepared incrementally on a line item basis. Actual expenditure bears little relation to approved budgets, making it impossible to relate health outputs to budgets either for planning or reporting purposes. Cambodia is an extreme example, with health centres receiving less than 10% of their budgets, but several other countries need to establish credibility.

Improvements in public expenditure management require action by central economic ministries, though implementation may also require reform and capacity building at sector and local Government level. External support to the health sector may need to be complemented by, or preceded by, support to cross-cutting reforms. Improved public expenditure management is always a central con-

cern of the policy dialogue associated with general budget support. In all cases, the PRSC policy matrix addresses issues of public expenditure management, and provides a vehicle for monitoring progress. In Benin, for example, the PRSC is supporting measures to overcome problems of low rates of budget execution that have prevented planned increases in health budgets.

### Summary Points

- Minimum standards of public expenditure management need to be attained before any health strategy can be effective.
- In good practice cases, PRSP identifies spending priorities in consultation with sectors, MTEF/budget process shifts resources towards them, review and adjust each year in light of performance.

## 8. Absorptive capacity

It is sometimes argued that the speed of any increase in donor flows needs to be constrained to the absorptive capacity of the countries. Very large increases in funding over a very short period of time, as envisaged in some estimates of the cost of reaching the MDGs, might well lead to difficulties in making good use of the money. However, the situation in most of the case study countries appears to be one of grossly inadequate funding that is increasing at a rate that could be easily absorbed and effectively used, provided that it is appropriately prioritised and managed without excessive bureaucracy. For many countries, existing capacity is underused because low operating budgets mean that drugs and other consumables are unavailable or have to be paid for, while staff lack the travel budget to expand outreach activities. Increased aid for non-salary recurrent costs and for financing free basic health services would enable existing capacity to be used: reducing user fees will increase utilisation of services, but only if quality does not decline, which requires the lost revenue from fees to be replaced by increased budget funding<sup>26</sup>. Increased funding would also help to overcome the more fundamental capacity problems caused by staff vacancies and by low output from underpaid staff who need to devote time to alternative occupations or private practice. These problems are capable of being relieved with additional funding for new recruitment and for salary increases, though the increase would need to be sustainable and should preferably be sequenced as part of an approach to performance management that links increased pay

to improved performance. Given time, contractual arrangements with non-government agents could be put in place to expand services and/or support capacity development. A balanced increase in funding that addresses the critical constraints in a logical sequence could be well used in most of the countries considered. However, very large disease-specific programmes (such as proposed HIV/AIDS treatment programmes in Guyana and Tanzania that envisage spending sums equal to half of the existing health budget) may well experience and cause capacity problems by drawing disproportionately on available staffing and other resources.

Concerns about absorptive capacity frequently reflect concerns about Governance and accountability rather than technical limits on spending, and the disbursement problems are the consequence of procedural requirements intended to address those concerns. There are cases where Governance and expenditure management constraints are so pervasive that major reforms need to precede or accompany increased funding (Tajikistan, Cambodia). In other cases, Government procedures are over-centralised and bureaucratic and need to be reformed to permit available funding to be spent (Benin, Burkina Faso). Action to address public expenditure management or civil service reforms requires action by central authorities as well as the health ministry, requiring coordinated action by Government that is mirrored by coordination between donor agency support to macro-level and sector level reforms. Donor project or pooled funding procedures are usually part of the problem (Box 1). Donor procedures not only cause low disbursement, they also divert capacity away from service delivery towards servicing the donor demand for meetings, field trips, reports, accounts, audits etc. By absorbing the capacity of financial management staff, they also get in the way of effective Government action to address the systemic weaknesses that make parallel procedures necessary.

### Summary Points

- On present trends, the binding constraint is lack of finance, not lack of capacity.
- Capacity problems can be managed if health strategies tackle bottlenecks in a logical sequence, and avoid large 'earmarked' commitments that distort health sector priorities.
- Where Government is committed to improving financial management, external partners should use Government systems while supporting coordinated action to strengthen them as necessary.

## 9. Reforming development assistance

The ways in which development assistance is committed and disbursed are major constraints on implementing public expenditure strategies. Commitments are too short term to be the basis for long-term strategies, disbursements are often a long way short of commitments, are unpredictable and subject to interruption for reasons outside the programme itself. Furthermore, the majority of development assistance continues to be committed through parallel arrangements that may be imperfectly coordinated with the Government strategy. There are problems with the data, but Box 2 presents some rough estimates of the significance of aid to the budget. Budget support is increasing as a share of donor support, but even in the most highly aid dependent countries it represents little more than half of the support for public expenditure, and less than one third of total aid flows. On average, less than 20% of donor disbursement is provided as budget support. This is a major problem in aid dependent countries where substantially more than half of health spending is often donor funded, and where the numbers of donors involved continue to increase. The priorities for increased spending are dominated by recurrent costs, spent at local level via geographically scattered cost centres, and remain difficult for donors to fund via project support

### Box 2 Where does all the aid go?

On average, for every \$1 disbursed by donors to our 14 case study countries, we estimate: -

● Direct donor spending (TA and direct payments) not recorded in balance of payments	US\$0.30
● Recorded in Balance of Payments, but not reported as part of Government spending	US\$0.20
● Aid earmarked to specific projects	US\$0.30
● Provided as Budget Support	US\$0.20

Some of the budget support is itself earmarked to specific sectors or budget lines.

Source: Foster, Mick, Full Report 2004 Tables 3.12-3.14

without incurring very high costs. If the case for an increase in health spending to progress towards the MDGs is accepted, it seems inescapable that the bulk of the increase will need to be provided as budget support<sup>27</sup>.

Meanwhile, countries continue to face the problem of coordinating large numbers of donors providing their assistance via multiple routes. Good practice approaches from our sample countries include:

- Joint Government-donor reviews of sector performance that are coordinated with the MTEF and national budget process which will feed in to a national PRS progress report or into a national public expenditure review process. There are a number of country examples where arrangements along these lines are in place, notably Uganda and Tanzania, where external partners work closely with Government in sector working groups, and where the sector dialogue is coordinated around the annual budget cycle.
- Indications of future donor funding should be made early enough in the year to be taken into account in setting ceilings for budget preparation, and should be confirmed as the budget is being finalised.
- Donor policy dialogue at different levels needs to be coordinated. The PRSC and general budget support groups are the appropriate vehicles for addressing issues that are crosscutting or are the concern of the central economic ministries. Of direct relevance to health, this includes the overall macro-economic framework, budget allocation, public finance management, civil service reform, and decentralisation. Where there is an established sector dialogue, the health content of the PRSC should rely upon the sector reviews to set and assess the achievement of sector level actions, as is the case in Uganda, avoiding overloading the budget support policy matrix with sector level detail.

Several of the country case studies suggest that large commitments from the global funds are distorting priorities in a number of countries by committing an unsustainable share of the budget to HAART for AIDS sufferers and sucking staff and resources into vertical programmes with costs that are neither replicable nor sustainable without longer-term commitments than the donors have yet provided (Tanzania, Guyana, Ethiopia). The Global Fund has in some countries set up separate coordination arrangements specific to the funds it is providing. Several countries are uncomfortable with the approach of some of these new actors. In August 2004, the Ministry of Finance in Uganda was reported as having decided to cap new project aid commitments that are outside the national health strategy. There is a strong case to argue that all external partners in the health sector should work entirely within existing health sector coordination arrangements and should provide their assistance in support of the PRSP strategy, focusing first on filling the financing gaps for implementing the PRSP.

#### Summary Points

- Progress towards the MDGs requires a further shift towards budget support as the main aid modality in aid dependent countries.
- All donors should participate in sector coordination, and should ensure that information is provided to Government to enable their commitments and disbursements to be fully captured in the macro-economic framework and reflected in public expenditure plans.
- Where Government has a sound sector strategy, the first call on donor funds should be to ensure that it is fully funded.
- Donors should try to commit early enough to inform the budget preparation.
- Where a strong sector level policy dialogue is in place, the PRSC should rely on sector reviews to agree sector level actions and to assess their achievement.

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# FISCAL SPACE AND SUSTAINABILITY FROM THE PERSPECTIVE OF THE HEALTH SECTOR

By Roger Hay and Gareth Williams, Paris, December 2005

# 4

## Executive Summary

This paper was commissioned by the Secretariat of the High Level Forum on the Health MDGs in response to a request from the second meeting of the High Level Forum in Abuja to clarify the meaning of the terms fiscal space and fiscal sustainability. Its purpose is to define the concepts of fiscal space and fiscal sustainability from the perspective of the health sector, and to demonstrate their usefulness in understanding the fiscal and macroeconomic issues that will arise from an increase in aid flows. The paper addresses the following questions:

- What is the meaning of the terms *fiscal space* and *fiscal sustainability* from the perspective of the health sector?
- In the light of likely scenarios for increased donor funding how much room is there to increase public health expenditures in a sustained way?
- How does the way aid is managed affect fiscal space and fiscal sustainability from the perspective of the health sector?
- What are the challenges for aid recipients to ensure the effective use of increased aid resources in the health sector?
- What are the macroeconomic effects of increased health spending and how might this influence fiscal space and sustainability in the long term?

The paper includes projections on future levels of public expenditure on health in low income countries under alternative scenarios for changes in future aid flows, budgetary reallocation, domestic revenues and growth. Under the more optimistic scenarios many countries will achieve levels of expenditure that would potentially allow them to be in a position to achieve the MDGs. This indicates that there is significant potential to create fiscal space for health spending in low income countries, in particular where an increase in aid is accompanied by budgetary reallocation in favour of health, faster growth and a stronger revenue effort.

However, the general conclusion of the paper is that the extent to which additional fiscal space

can be created and sustained depends crucially on the way both aid suppliers and its recipients manage additional aid flows. Combinations of donor and recipient behavior will determine how effectively and durably additional aid will expand fiscal space. Some of these are summarized in the table below. The best combinations suggest that fiscal space can be expanded quickly and reliably ('Green Zone'); the worst that great caution should be exercised until reforms have shown signs of success ('Red Zone')

**More specifically, the main priorities identified for aid donors include:**

### *Ensuring longer term predictability of aid flows*

Donors have signaled their intention to increase aid flows substantially, but recipient governments are faced with a great deal of uncertainty about the level of support that they can expect in the future. On the basis of past experience, recipient governments may be reluctant to increase health expenditures, especially where new spending implies long term recurrent expenditure commitments. Unless donors can provide longer term commitments and more predictable aid flows, additional aid may not generate much additional fiscal space for health spending.

### *Reducing short term aid volatility*

This paper highlights the extent of aid volatility and demonstrates that this is associated with significant instabilities in public expenditures on health. These, in turn, distort resource allocation and have negative consequences for service delivery and health outcomes. The risks of short term volatility may provide an additional reason for governments to be wary of budgeting on the basis of additional aid resources. Donors need to address the risk that scaling up aid will generate even greater volatility and more disruptive effects.

### *Coordination, harmonization and alignment*

Uncoordinated, off-budget and projectised aid contributes little to durable fiscal space. Aid effectiveness

## Conditions for the sustainable expansion of fiscal space

	Donor policies	Recipient policies
<b>Green Zone</b> Far reaching changes in donor and government behaviour allow fiscal space to be expanded rapidly and sustainably	Donors are able to make long term commitments to scale up aid	Governments have affordable long term investment and expenditure plans
	Donor aid flows are predictable and stable	Increase in aid is accompanied by a stronger tax effort
	Donors are able to coordinate and harmonize aid, and thereby reduce recipients' transactions costs	Governments are able to finance any residual cash-flow variations
		Governments are able to take responsibility for the management of donor aid, and bring it on budget
<b>Amber Zone</b> Partial reforms in donor and government behaviour allow some increase in fiscal space, but problems of fiscal sustainability remain	Some progress in increasing the long term predictability of aid and reducing short term volatility	Where justified, governments reallocate budgets in favour of the health sector
	Some initiatives to improve donor coordination and harmonization, but limited use of budget support	Government health systems are efficient, effective and equitable
		Governments may take on new spending commitments that cannot be sustained
		Governments do not improve their revenue effort
<b>Red Zone</b> Great caution should be exercised in raising health expenditure until reforms in donor and government policies show success	Donors are unable to make long term commitments or reduce aid flow volatility	Governments are unable to fully finance cash-flow instabilities.
		Public expenditure management systems are not yet robust enough to account for aid expenditure on budget
		Very weak public expenditure management
	Aid remains highly fragmented and projectized.	Donor spending remains largely off-budget
		Governments do not improve their revenue effort
		Health care providers are not well motivated or managed
		The poor do not benefit from public health expenditure

would be increased if aid coordination was improved, and the alignment of donor funding with national priorities were strengthened. Where conditions allow, the greater use of budget support would be desirable. There are encouraging signs of improved donor practice, including the recent Paris Declaration on Aid Effectiveness. However, there are contradictory tendencies in the health sector, where an increasing share of aid is provided through global health initiatives that tend to operate through parallel structures outside government budgets and management systems.

### The main priorities identified for recipients include:

#### *Ensuring fiscal sustainability*

Ensuring the fiscal sustainability of health expenditures will be a major challenge for recipient governments, particularly low income countries facing 'windfall aid incomes'. There is a risk that some governments will make capital investments that they cannot fully maintain, take on too many staff to pay properly, or take on other new spending

commitments that prove to be unaffordable and unsustainable in the long term. On the other hand concerns about the unpredictability and unreliability of aid flows may cause some governments to be overly cautious about using additional aid to augment health expenditures financed from domestic resources. The key to ensuring fiscal sustainability is for recipient governments to take a long term view of expenditure commitments, growth and mobilizing domestic revenues.

#### *Using aid productively*

In the long term the main source of additional fiscal space will be economic growth. It is therefore crucial that recipient governments use aid in productive ways. Careful judgements will need to be made on the allocation of public expenditure between and within sectors taking into account the best available evidence of the impact of public expenditure on human development and economic growth. The central challenge will be to improve the efficiency of health systems to ensure that higher spending will generate improved health

outcomes. In many cases reallocating resources within the health sector towards primary health care would improve efficiency and equity.

### *Addressing absorptive capacity constraints*

Important capacity constraints arise from organizational, managerial and governance weaknesses, which may reduce the returns to additional aid and public expenditure substantially. In these conditions it will be important to scale up aid at a measured pace, and to accompany this with institutional and governance reforms to create conditions where aid can be used effectively.

### *Taking account of the macroeconomic effects of higher aid inflows*

There are macroeconomic risks associated with scaling up aid, in particular real exchange rate appreciation and the crowding out of private sector investment. Development aid for health is no different to other types of aid in this respect. In many cases increases in donor support to the health sector will still be warranted, in particular where this supports expenditure that provides the public goods and generates the human capital that will be required to enable private sector-led growth in future. However, the impact on private sector investment and consumption should always be considered. At a certain level of public spending the marginal costs of additional expenditure will exceed its marginal benefits. This constitutes an upper limit to fiscal space that no government should exceed irrespective of the amount of aid on offer. It is difficult to establish where this limit lies. However, most would argue that the poorest countries are some way from reaching this limit. With careful economic management to ensure that scaled-up aid supports both improved service delivery and growth, fiscal space can still be expanded.

## **1. Introduction**

It is widely recognized that current levels of public expenditure for health in low income countries are too low to achieve the MDGs. The prospect of substantial increases in aid may allow higher levels of health spending in low income countries. However, there is a great deal of discussion about the extent to which these additional resources can be used effectively to raise expenditure on health to a higher level. In other words, to what extent can fiscal space for health spending be expanded in a sustainable way?

This paper was commissioned by the Secretariat of the High Level Forum on the Health MDGs in response to a request from the 2<sup>nd</sup> HLF in Abuja to clarify the meaning of the terms fiscal space and fiscal sustainability<sup>1</sup>. Its purpose is to define the concepts of fiscal space and fiscal sustainability from the perspective of the health sector, and to demonstrate their usefulness in understanding the fiscal and macroeconomic issues that will arise from an increase in aid flows. The paper is structured around the following questions:

- What is the meaning of the terms **fiscal space** and **fiscal sustainability** from the perspective of the health sector?
- In the light of likely scenarios for increased donor funding how much room is there to increase public health expenditures in a sustained way?
- How does the way aid is managed affect fiscal space and fiscal sustainability from the perspective of the health sector?
- What are the challenges for aid recipients to ensure the effective use of increased aid resources in the health sector?
- What are the macroeconomic effects of increased health spending and how might this influence fiscal space and sustainability in the long term?

The paper will provide a broad overview of these issues, but it must be acknowledged from the outset that it is often difficult to reach firm conclusions because the evidence base is rather limited.

Although the issues it raises are relevant to all countries, the focus of the paper is on low income countries. This is because fiscal space and sustainability are particularly serious constraints in low income countries, and are one of the main obstacles to achieving the MDGs. The arguments about scaling-up aid are also most relevant to low income countries, in particular those countries (notably in Sub-Saharan Africa) where donor aid amounts to a substantial proportion of public spending.

## **2. Defining fiscal space and fiscal sustainability**

### **a. Fiscal space**

Fiscal space refers to the ability of governments to make budgetary resources available for desired purposes. However, the term has been used in different ways, and its precise definition remains somewhat unclear. More restrictive interpretations of fiscal space emphasize hard budget constraints and expen-



diture ceilings that are designed to ensure macro-economic stability and the availability of credit to the private sector. Advocates of a more flexible approach argue that it should be possible to support higher levels of public expenditure on meritorious goods and services that are crucial for poverty reduction, growth and achieving the MDGs.

The following definition of fiscal space taken from a recent IMF paper has been adopted here because it is sufficiently broad to encompass all of the key issues that influence judgements on the appropriate level of public expenditure.

*“Fiscal space can be defined as the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government’s financial position.” (Heller, 2005)*

This paper is specifically concerned with issues surrounding public expenditure in the health sector. However, it is not possible to restrict the view of fiscal space to one particular sector. The budgetary resources made available to the health sector depend on the government’s overall fiscal policies, the demands of competing sectors, and spill-over effects from one sector to another. In any event, the size of the health budget is the result of a set of political decisions on the allocation of public resources between competing priorities.

Although fiscal space is a broad concept that applies to public expenditure as a whole, there are valid reasons for considering the problem from the perspective of the health sector. Considerations about the potential to increase public expenditure on health need to be placed within the context of the government’s fiscal position. Spending decisions in the health sector also have an important influence on the government’s fiscal position. For example, a decision to hire large numbers of additional health workers would generate upward pressure on civil service salaries and the overall public sector wage bill. Health sector policy and expenditure decisions will therefore influence fiscal space and vice versa.

In principle, there are several ways to create fiscal space for additional health spending that reflect the government’s budget arithmetic. Each offers opportunities, but all also have their limitations. Well managed fiscal policy assesses the costs and benefits of each, as well as their political implications.

#### *i) Increase discretionary expenditure from debt reduction*

In a number of cases the amount of fiscal space available in low income countries for spending on public services, including health, is constrained by their obligations to debt servicing. In a few cases, these obligations may amount to around 50 % of total public spending. Hence the significance of recent initiatives to reduce low income country public debt.

#### *ii) Reallocation between sectors*

Health sector spending can be increased by reallocating expenditure from other sectors. As part of HIPC and PRSP processes some governments in low income countries have increased the share of the budget allocated to the health sector, and some are committed to further increases. However, the demands of other sectors will inevitably impose a limit on the share of expenditure that can be allocated to health. This issue is discussed further in section 5.1.

#### *iii) Mobilisation of domestic revenues*

Governments can raise additional revenues by increasing tax rates, creating new taxes and levies and strengthening tax collection. The low tax effort in many low income countries (usually less than 15% of GDP) indicates that there is scope to mobilise additional domestic revenues. However, experience suggests that it will be difficult to achieve a rapid improvement in revenue ratios. The Commission for Macroeconomics and Health forecasts that low income countries would probably only be able to increase their revenue ratios by 2% of GDP by 2015 (CMH, 2001). The Millennium Project suggests that a 4% increase in the revenue ratio may be feasible (Millennium Project, 2005). While increases in the tax effort may generate modest increases in fiscal space, the most important challenge will be to accelerate economic growth, which will be essential to generate the sustained increases in domestic revenues required to finance improved health services.

#### *iv) Increase borrowing*

Governments can also finance higher levels of public spending by borrowing from domestic and foreign creditors. However, there are costs in terms of future debt service obligations and the potential crowding out of private sector borrowing. A sound fiscal principle is that over the economic cycle governments should borrow only to invest rather than to finance recurrent expenditure. While health expenditures are generally treated as recurrent expenditure,

many have argued that they should be viewed as an investment in human capital that will generate taxable returns in the long run. If this view is accepted then it would be justified to finance a higher level of public expenditure on health through borrowing so long as the expected returns exceed the costs of servicing the debt.

#### v) *Increase aid*

The fiscal space that is generated by aid depends on the level, duration and predictability of donor funding, as well as on the type of aid. As discussed later aid will generate more fiscal space where donors can make long term financial commitments and can disburse aid in a predictable manner. The effect of aid on fiscal space will also depend on whether it is provided as grants or loans, whether or not it enters the government's budget, whether it is earmarked for a particular use or sector, and the extent to which it is fungible. These issues are discussed further in section 4.

#### vi) *Seignorage*

Governments can finance additional expenditure by printing money, but the opportunities to generate seignorage revenues without causing inflation are very limited.

An important aspect of health financing in low income countries is the high proportion of health expenditures that are privately financed, usually out of pocket. The relationship between public and private expenditure on health, and the implications for fiscal space are complex. An increase in public expenditure on health may substitute or complement private spending. Where substitution occurs the net provision of services may not increase. However, shifting health financing from private to public sources may improve economic efficiency where this improves the cost effectiveness of service delivery or frees up private resources to be used more productively elsewhere. In the long run such efficiency gains would have a positive effect on growth and government revenues, and thereby generate fiscal space. Public spending on health may also be preferable on equity grounds, in particular because it partially insures the poor against catastrophic medical costs. However, it must be emphasised that all of these effects are poorly understood and subject to considerable uncertainty.

## b. Fiscal sustainability

The concept of fiscal sustainability refers to the ability of government to sustain spending on a desired

purpose for its planned duration, and to meet the cost of borrowing without compromising the government's financial position. There are three conditions that need to be met in order to achieve fiscal sustainability in a strict sense:

- *For expenditures funded by loans.* The financial returns generated by the additional expenditure should cover the costs of borrowing.
- *For recurrent expenditures funded by donor grants.* Governments must be able to raise alternative sources of revenue to replace donor funding when it is phased out, if it is intended to continue these expenditures beyond the planned period of donor funding
- *For all investments.* Governments must be able to cover the recurrent costs of any new capital investment, for example the operation and maintenance costs of the construction of a new health facility, as well as the costs of capital.

Health sector spending presents particular challenges in relation to all three of these conditions. With respect to the first, it is usually impossible to assess whether or not it is justified on economic grounds to borrow in order to finance health spending. This is because there is considerable uncertainty about the economic impact of health programmes and the level and timing of any financial return. However, it is generally considered reasonable to allow a certain level of borrowing on concessional terms to finance health programmes in low income countries so long as the government's overall financial position provides sufficient capacity to service the consequent debt.

In relation to the second, the planned duration of health programmes usually far exceeds the duration of donor commitments, which typically only cover a few years. It is therefore essential that governments consider how such programmes could be financed if donor funding were unavailable in the future. This highlights the importance of strengthening the tax effort and developing non-tax sources of health financing.

On the third point, public spending in the sector is mainly in the form of salaries for staff and drug purchases: both are long-term, recurrent cost commitments that governments must be in a position to finance. Cutting these expenditures will impose high political costs, and would have damaging medical consequences. There are relatively few one-off activities that can be undertaken to improve public health.

Fiscal sustainability is a particularly important issue in the context of scaling up aid because it is not certain how long the increase in aid volumes will last. At some point in the future governments will need to mobilise additional domestic revenues in order to offset a decline in aid flows. However, it is difficult to predict how government revenues will develop under conditions of higher aid. Where aid is successful in generating growth there may be a positive effect on domestic revenues. However, there is also a risk of moral hazard: governments may relax their fiscal effort when aid is easily available. The empirical evidence of these issues is rather inconclusive. Most studies find that there is no general relationship between aid and domestic revenues, and that the fiscal response varies in different country contexts (McGillivray and Morrissey, 2001; Fagernäs and Roberts, 2004). Gupta *et al.* (2005) find that there is a difference in the fiscal response to grants and concessional loans: aid provided as grants tends to result in reduced domestic revenues, especially in countries with weak institutions, whereas aid provided as loans results in a slight increase in domestic revenues.

In view of these uncertainties it is helpful to consider various alternative country scenarios for the future evolution of domestic revenues. Figure 1 presents three scenarios that have different implications for fiscal sustainability. The first scenario presents the most optimistic case where aid recipients' benefit from a permanent increase in fiscal space. When aid begins to decline the effect is offset by increasing domestic revenues resulting from growth or a stronger tax effort. In the second scenario, the increase in fiscal space is temporary because when aid begins to decline it is not compensated by an increase in domestic revenues. In this case additional expenditures cannot be sustained beyond

the duration of higher aid flows. The third scenario represents the most pessimistic case where recipient governments reduce their tax effort in response to higher aid flows. Following the decline in aid, fiscal space will be more limited than it is at present.

While these scenarios affect government spending overall, there are particular implications for the health sector. Because health expenditures usually entail long term recurrent spending commitments there are particular risks for governments under scenarios two and three. In these two cases increased health spending will not be fiscally sustainable. Fiscally prudent governments may decide not to spend additional donor resources on health, and may instead increase spending in other sectors, which do not generate such long term obligations. An additional problem that is discussed more fully in section 4 is that aid is unpredictable and governments cannot accurately forecast future levels of aid. This is another reason why governments will tend to be cautious in raising health expenditures.

### 3. How much room is there to increase health expenditures?

A key question is how much additional fiscal space can be created under plausible scenarios for increased aid, domestic revenues and economic growth. This section addresses this question by first outlining trends in public expenditure on health and foreign aid in low income countries, and then simulating the effect of changes in key public finance variables on health spending under several alternative scenarios.

#### a. Recent patterns of public health spending in low income countries

Figure 2 compares public expenditure on health in 55 low income countries in 2002 measured in per

**Figure 1 Fiscal space and sustainability under alternative scenarios for aid and domestic revenues**

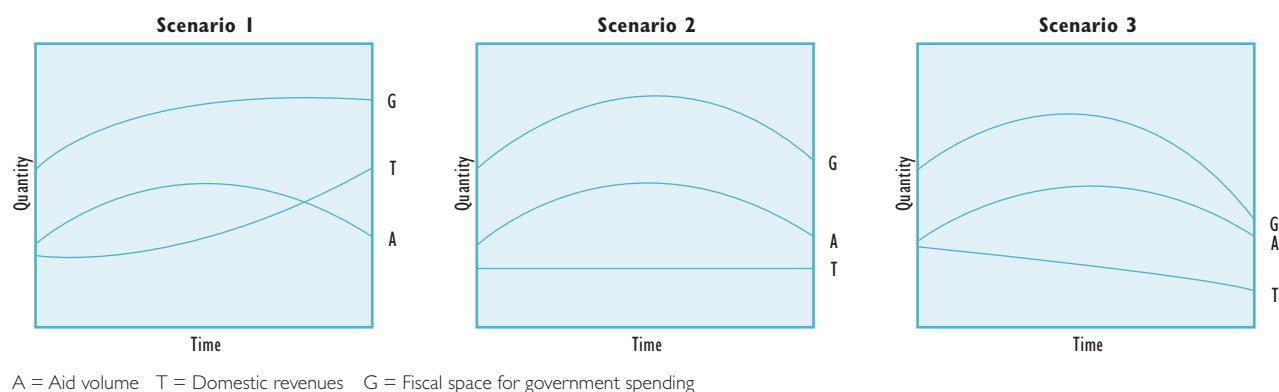


Figure 2 Public expenditure on health in low income countries

Source: World Health Report (2005)



capita terms and as a percentage of GDP<sup>2</sup>. Average expenditure was \$6.17 per capita per annum or 2.53% of GDP<sup>3</sup>. There are significant variations between countries, but very few countries spend more than 5% of GDP.

Over the past few years there has been a gradual trend towards higher public expenditure on health in low income countries. Average public expenditure per capita on health, in low income countries, rose by 12% from \$5.49 in 1998 to \$6.17 in 2002. Expressed as a percentage of GDP, public expenditure on health rose from 2.26% to 2.53% over the same period.

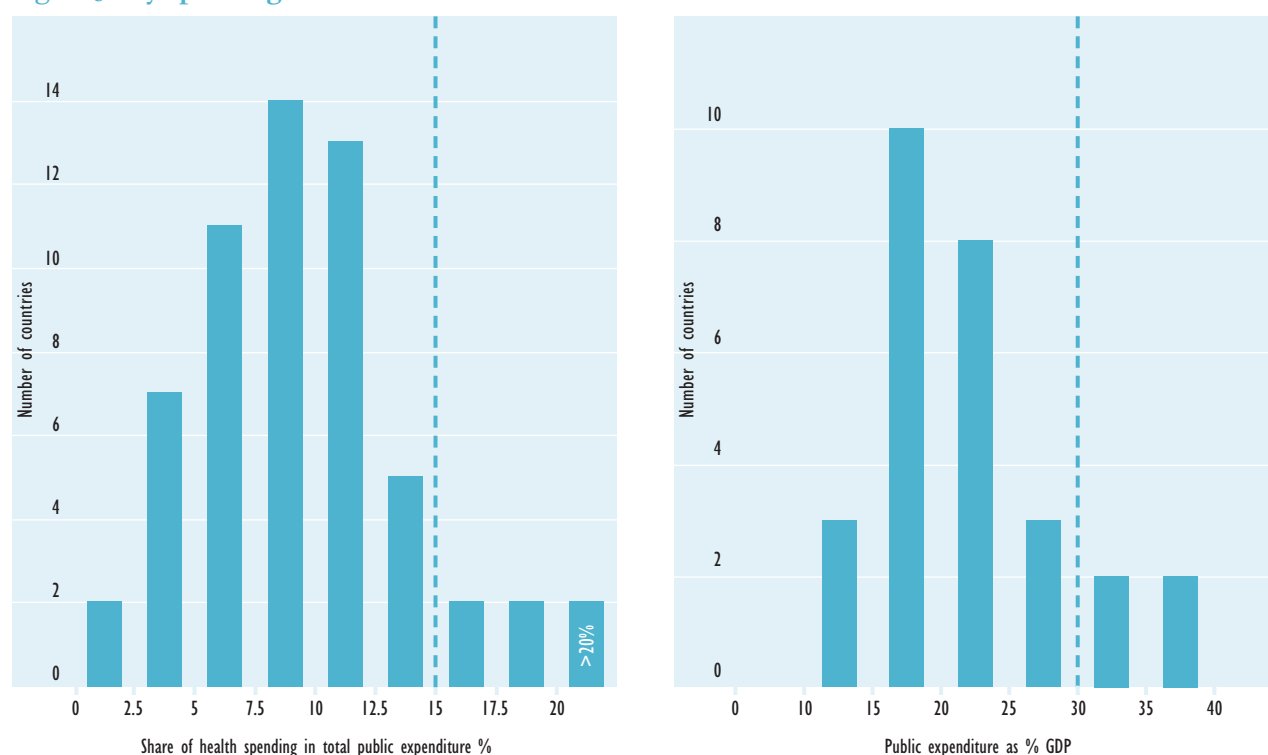
In spite of recent modest increases, public expenditure on health in low income countries is still far below the minimum levels required to achieve the health MDGs. The recently published Millennium Project report provides costings for the MDGs in 5 low income countries, and suggests that in these countries present levels of expenditure on health would need to increase by \$30-48 by 2015 in order to achieve the health MDGs (Millennium Project, 2005). The Commission for Macroeconomics and Health calculated that a minimum total health expenditure of \$34 per capita in 2007 (rising to \$38 in 2015) would be required to provide a basic package of essential health interventions (Commission for Macroeconomic and Health, 2001). Public health spending in the low income countries shown in figure 2 is below this level in all but two cases<sup>4</sup>.

In order to analyse the scope for increasing health expenditures it is important to examine two key ratios: (i) the share of health spending in total public spending, and (ii) government spending as a percentage of GDP<sup>5</sup>. Figure 3 groups low income countries according to the first ratio. It indicates that the majority of low income countries allocate less than 10% of the government budget to health. Very few countries spend more than 15% of their budget on health, in spite of the 2001 declaration by African leaders in Abuja to increase spending to this level. There appears to be an effective ceiling on health spending at around 15% of the government budget. This reflects the competing demands of other sectors and the political constraints to reallocating resources in favour of health.

The second chart shows public expenditure as a percentage of GDP in a sample of 28 low income countries for which adequate data is available. The mean value is around 22% of GDP. There is much variation between countries, but there are few cases where government expenditure exceeds 30% of GDP<sup>6</sup>.

These figures are significant because they suggest that there is an upper limit on health spending in low income countries. Since very few allocate more than 15% of government spending to health, and public expenditure is generally less than 30% of GDP, fiscal space for health spending will usually be limited to 5% of GDP (this is confirmed in figure 2). Because public expenditure on health accounts

Figure 3 Key spending ratios in low income countries



Sources: World Health Report (2005), IMF (GFS)



for an average of 2.5% of GDP in low income countries, there will often be scope to increase health spending by one or both of the two fiscal adjustments<sup>7</sup>. However, the resources that can be generated in these ways will be relatively modest. In a typical low income country with a GDP per capita of \$400, an increase in health expenditures from 2.5% to 5% of GDP would amount to additional spending of just \$10 per capita per annum. Although this would double the public resources available for health, which would be helpful, it falls well short of the resources estimated by the Commission for Macroeconomics and Health to be required to finance a basic package of health services. The only way to create additional fiscal space beyond this limit is to increase GDP per capita through economic growth.

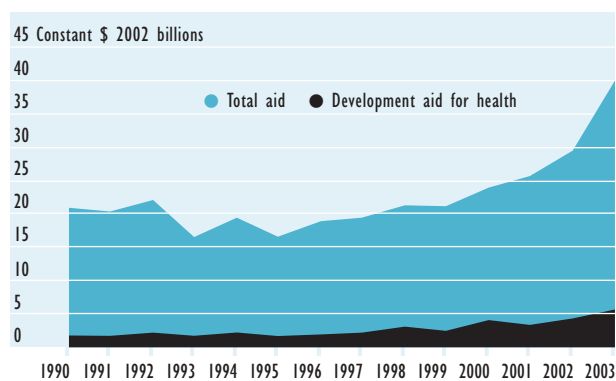
### b. Trends in development aid for health

Many low income countries, particularly in Sub-Saharan Africa, are dependent on foreign aid for a substantial proportion of their revenues and public expenditure. The creation of additional fiscal space for increased health expenditure will therefore depend greatly on future increases in foreign aid. In order to develop probable scenarios for scaling up aid it is useful to review trends in aid flows to low income countries.

Data on aid flows is provided in terms of commitments, which refer to pledges made by donors in a certain year, and disbursements, which refer to the money that is actually transferred to the recipient. From the perspective of fiscal space, disbursements are the more relevant measure. However, information on the sectoral composition of aid is only available in terms of commitments. Figure 4 shows total aid commitments to low income countries for the period 1990 to 2003 and the share of aid committed for health. This indicates that development aid commitments for health in low income countries increased from around \$1.7bn in 1990 to \$5.6bn in 2003<sup>8</sup>. Over this period its share of total aid commitments increased from 9% to 17%. Much of this increase has been driven by increased funding commitments for HIV/AIDS, the bulk of which has been mobilised through the Global Fund (GFATM) and the US President's Emergency Plan For AIDS Relief (PEPFAR). Global bilateral and multilateral commitments for HIV/AIDS increased from \$1.2bn in 2000 to \$3.4bn in 2004 (Lewis, 2005).

While these figures indicate a substantial level of donor funding for the health sector, it is important to put them in perspective. The \$5.6bn committed

**Figure 4 Aid commitments to low income countries since 1990**



Sources: OECD DAC Creditor Reporting System

in 2003 amounts to only \$2.56 per capita in all low income countries. Although this amounts to 42% of public expenditure on health, it is a modest contribution in relation to needs.

Development aid for health appears more significant if the analysis is restricted to low income countries in sub-Saharan Africa. In 2003 development aid for health totalled \$3.8bn in these countries, or \$6.08 per head. This figure is equivalent to average public spending per capita on health in sub-Saharan Africa, and indicates the extreme aid dependence of these countries.

Data on aid disbursements indicate a similar upward trend. However, they are not available on a sectoral level. Public statements made by donors following the Monterrey conference and the G8 summit in Gleneagles indicate that net aid disbursements to all developing countries are likely to increase from around \$80 billion now to \$130 billion in 2010. Net disbursements to Africa are projected to double between now and 2010 (OECD DAC estimates).

### c. Projections of fiscal space for health spending under alternative scenarios

It should be clear from the above discussion that the maximum expansion of fiscal space for health spending depends on a combination of measures: increases in the share of public expenditure allocated to health; increases in domestic revenues and, in the right conditions, increases in aid. None of these measures is likely to be sufficient on its own, and the mix of measures adopted by an individual country will depend on what the potential yield from each measure is likely to be, taking into account costs, risks, institutional strengths and economic prospects. This section presents some simple projections on the future level of public expenditure

per capita on health in individual low income countries under alternative scenarios when the measures above are combined in different ways:

- *Aid.* The projections are based on the assumption that the aid/GDP ratio doubles between now and 2015. In order to take account of the effect of volatility, the present level of aid is taken to be the average level of net disbursements over the three most recent years for which data is available.
- *Proportion of the government budget spent on health.* It is assumed under most scenarios that governments continue to spend the same share of their budget on health in 2015 as they do presently. Under some scenarios it is assumed that governments increase the share of the government budget spent on health to 15% in line with the 2001 Abuja Declaration<sup>9</sup>.
- *Growth.* Under most scenarios it is assumed that economic growth continues at the average rate for the past ten years. Certain scenarios simulate the effect of increasing the growth rate to 2% above the long term average.
- *Domestic revenues.* Under most scenarios it is assumed that the ratio of domestic revenues to GDP remains constant. The final scenario simulates the effect of increasing this ratio by 4% of GDP by 2015 (in line with the projections of the Millennium Project).

The five alternative scenarios are described in table 1 below:

Simulations of public expenditure on health under the five scenarios were conducted for 30 low income countries for which adequate data were available. Table 2 shows how many of these countries will reach different levels of public expenditure on health in 2015 under the five scenarios.

The simulations make a number of important assumptions. First, the projections are based on the assumption that government spending is equivalent to the sum of domestic revenues and net aid disbursements, and that there is no fiscal deficit. Second, aid is assumed to be on-budget and fungible between sectors. Third, it is assumed that population continues to increase at present growth rates.

Countries spending more than \$30 per capita are shown within the grey zone on the table. Following the analysis of the Commission on Macroeconomics and Health this is considered to be the minimum level of public expenditure required to provide a minimum package of essential health services<sup>10</sup>.

The table indicates that the doubling of aid alone (scenario 2) makes a relatively modest contribution to fiscal space. The average increase in public expenditure above the base case is around \$4 per capita, and only 3 countries out of thirty achieve public expenditure on health greater than \$30 per capita (compared to 2 countries in the base case), and these were already spending most.

Combining increased aid with a reallocation of public expenditure in favour of health would allow a more substantial increase in health spending. This is modelled under scenario 3, which assumes that

**Table 1 Alternative scenarios for aid, public finance and macroeconomic variables**

Scenario description	Scenario 1 Base case	Scenario 2 Higher aid	Scenario 3 Budgetary reallocation	Scenario 4 Faster growth	Scenario 5 Higher revenue ratio
Aid/GDP ratio	Aid/GDP ratio remains at current level	Aid/GDP ratio doubles by 2015	Aid/GDP ratio doubles by 2015	Aid/GDP ratio doubles by 2015	Aid/GDP ratio doubles by 2015
Proportion of the government budget spent on health	Health share of budget held constant	Health share of budget held constant	Health share of budget increases to 15%	Health share of budget increases to 15%	Health share of budget increases to 15%
Growth rate 2005-2015	Growth continues at its long term average rate	Growth continues at its long term average rate	Growth continues at its long term average rate	Growth increases to 2% above its long term average rate	Growth increases to 2% above its long term average rate
Domestic revenues/GDP	Present ratio of domestic revenues to GDP is maintained	Present ratio of domestic revenues to GDP is maintained	Present ratio of domestic revenues to GDP is maintained	Present ratio of domestic revenues to GDP is maintained	Ratio of domestic revenues to GDP increases by 4% by 2015

**Table 2 Projections of per capita public expenditure on health in 2015**

Projected public expenditure per capita on health in 2015	Numbers of countries falling into each expenditure class for each scenario				
	Scenario 1 Base case	Scenario 2 Higher aid	Scenario 3 Budgetary reallocation	Scenario 4 Faster growth	Scenario 5 Higher revenue ratio
\$ 0 - 5	6	5	0	0	0
\$ 5 - 10	12	5	4	1	1
\$ 10 - 15	6	11	5	4	3
\$ 15 - 20	3	3	6	6	3
\$ 20 - 25	0	2	3	4	6
\$ 25 - 30	1	1	4	2	2
\$ 30 - 40	1	1	3	6	5
\$ 40 - 50	1	0	3	1	3
\$ 50 - 60	0	1	0	4	4
\$ 60 - 80	0	1	2	0	1
\$ 80 - 100	0	0	0	2	1
\$ 100 +	0	0	0	0	1
Average per capita public expenditure on health for all 30 countries	\$11.63	\$15.52	\$24.94	\$31.97	\$35.73

Data sources: Revenue data (IMF GFS), health spending (WHO World Health Report), aid (OECD DAC database), other variables (World Bank, World Development Indicators).

15% of the budget is spent on health. The projections indicate that under this scenario average public expenditure on health would increase to nearly \$25 per capita by 2015, and spending in 8 countries would exceed \$30 per capita.

The effect on fiscal space is even more pronounced where increased aid and budgetary reallocation is accompanied by faster growth. Scenario 4 describes cases where growth accelerates to 2% above the long term average. In this case average public expenditure per capita on health exceeds to \$30 by 2015, although spending in slightly more than half of the countries remains below this level.

Scenario 5 describes the best of all cases where additional fiscal space is created by a stronger revenue effort, in addition to faster growth, budgetary reallocation and increased aid.

The Millennium Project has provided detailed costings of the additional resources required to meet the MDGs in five low income countries. For three of these countries adequate data was available to simulate whether health spending would reach these targets under the five scenarios. The results are presented in table 3. It is notable that none of the three countries would achieve the required additional health spending under scenarios one to

**Table 3 Projections of fiscal space compared with MDG spending targets**

	Additional per capita spending in 2015 required to meet health MDGs/ 2003 US\$	Additional per capita public expenditure on health in 2015 projected under alternative scenarios / US\$				
		Scenario 1 Base case	Scenario 2	Scenario 3	Scenario 4	Scenario 5
Cambodia	32.00	5.01	10.59	20.70	28.06	32.25
Tanzania	48.00	2.75	8.05	12.62	18.22	21.14
Uganda	44.00	3.15	7.39	16.90	22.85	25.84

four. Only Cambodia would reach the target under scenario five<sup>11</sup>.

#### d. Interpreting the results of the projections

The above simulations indicate that there is significant scope to create fiscal space for health spending in low income countries, in particular where an increase in aid is accompanied by budgetary reallocation in favour of health, faster growth and a stronger revenue effort. Under the more optimistic scenarios many countries will achieve levels of expenditure that would potentially allow them to be in a position to achieve the MDGs, but probably not by 2015 as any effects of increased spending would be lagged. Although many countries do not reach this level of spending under any scenario, there would still be a substantial increase in health expenditures that could make a significant difference to service delivery and health outcomes.

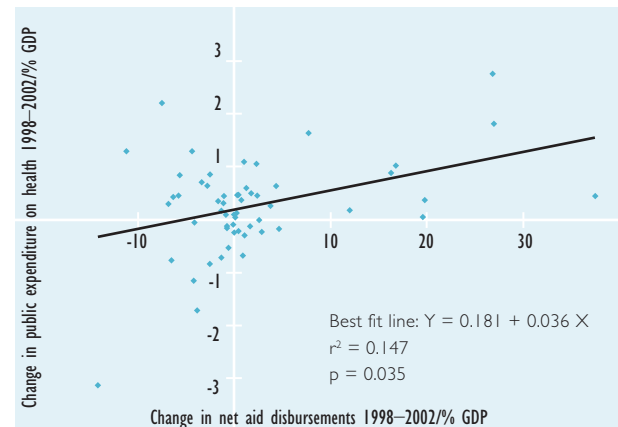
The above projections provide a useful indication of the additional fiscal space that may potentially become available under alternative scenarios. However, the scenarios are generally rather optimistic, and the projected expenditures should be regarded as being at the top end of what may be feasible. There are several reasons for caution:

- It is probably too optimistic to assume that governments will allocate 15% of public expenditure to the health sector. Very few low income countries have achieved this (see figure 3).
- Aid recipients may be inclined to allocate a relatively small share of additional aid to the health sector because of the unpredictability of aid and the long term recurrent spending commitments that are generated by health expenditures.
- The assumption that additional aid will be provided on-budget is not realistic given present patterns of aid delivery (see 4.2).
- An average increase in the revenue/GDP ratio of 4% by 2015 would represent a very strong tax effort that would only be achieved by the best performing countries.

#### e. Empirical evidence on the relationship between aid and public spending on health

In order to assess how public expenditure on health would respond to increases in aid it is instructive to examine aid recipients' past behaviour in utilising additional aid flows. Theory suggests that governments will shift their own resources away from sectors that benefit from international aid (fungibility). The empirical evidence on this point suggests

**Figure 5 Response of public expenditure on health to changes in aid**



Sources: OECD DAC database on aid disbursements, WHO World Health Report 2005

NB: Values for net aid disbursements and public expenditure over the period 1998-2002 were adjusted using a Hodrick-Prescott filter. The effect of the filter is to indicate the trend in values over the five year period and to strip out the effect of volatility from one year to the next.

that the fiscal response to aid varies greatly between countries.

Figure 5 plots changes in net aid disbursements over the period 1998 to 2002 against changes in public expenditure on health over the same period in 56 low income countries. Although there is a wide variation in the fiscal behaviour of different countries, there is a statistically significant correlation between changes in aid volumes and changes in public expenditure on health. The slope of the best fit line shows that the effect of additional aid on health expenditures has been quite small: an increase in aid of 10% of GDP has been associated with an increase in public expenditure on health of 0.36% of GDP. This would imply that only 3.6% of aid is used to finance health expenditures.

Given that low income countries typically spend around 2.5% of GDP on public health expenditure, this implies that aid stimulates health spending to a slightly greater degree than domestic revenues. However, there is significant fungibility in the use of aid. Although donors earmark 17% of their commitments (see section 3.2), the increase in health spending generated by an increase in aid is far less than this. The explanation is that governments have responded to increases in aid for the health sector by shifting their own resources out of the health sector.

This finding indicates that if governments maintain their present fiscal behaviour, future increases in aid will only generate relatively modest increases in public expenditure on health. Much will depend

on whether governments' fiscal behaviour will change in the future, most importantly by reallocating donor and domestic resources in favour of health.

#### 4. How does donor behaviour affect fiscal space and sustainability?

This paper has so far considered the potential effects of changes in the aggregate level of aid volumes on the recipient's fiscal space. However, there are other aspects of donor behaviour that have an important effect on fiscal space and sustainability. This section considers two important problems: (i) the volatility and unpredictability of aid, and (ii) its lack of coordination, harmonisation and alignment. It will be argued that the maximum additional fiscal space will not be created unless these problems are addressed.

##### a. Aid volatility and unpredictability

Aid commitments and disbursements fluctuate considerably over time. There are various types of instability caused by different aspects of donor behaviour:

- *Short term volatility from one year to the next.* This is often the result of project management and disbursement delays, exchange rate fluctuations, non-compliance with agreed conditionality, and political problems in recipient countries.
- *Commitment–disbursement gaps.* Donors often cancel their commitments or delay disbursements by several years.
- *Longer term unpredictability of aid.* Donors are usually unable to make long-term aid commitments because the length of donor programming cycles is typically only a few years. In addition, bilateral aid commitments are typically dependent on the donor country's political cycle: a change in government can make a great difference to a donor country's aid policies.

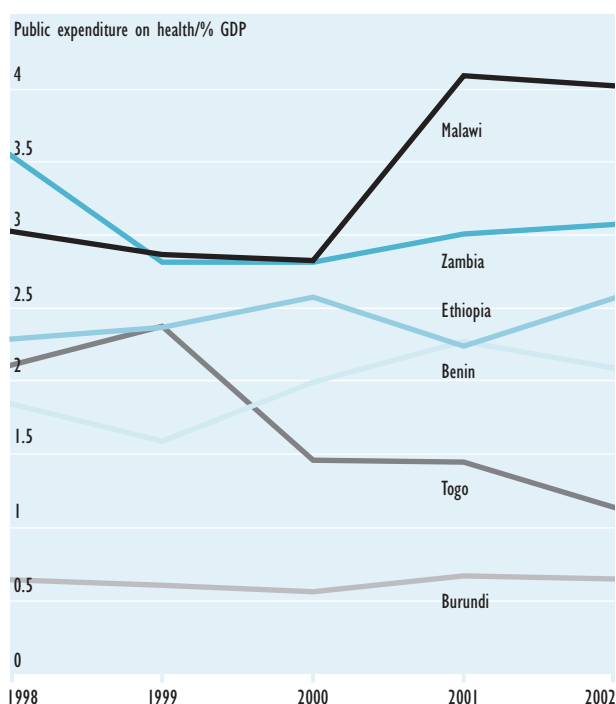
The instability of aid can be measured both in terms of aid commitments and disbursements. Aid commitments are by nature very unstable because they reflect periodic announcements by donors of new projects and programmes covering several years. They also provide an uncertain basis for governments to plan expenditures over the medium term. On average donors disburse only around two thirds of the aid they have committed, and in low income countries this ratio is only about 50% (Bulir and

Hamann, 2005). There is evidence that the gap between commitments and disbursements is widening. The ratio of disbursements to commitments for all recipient countries fell from 82% to 66% between 1990 and 2001 (Bulir and Hamann, 2005).

Volatility in disbursements creates particularly difficult problems for recipient countries because when expected aid resources do not arrive governments are unable to execute budgets as planned. Recent empirical studies indicate that there is substantial volatility in aid disbursements. Bulir and Hamann (2005) demonstrate that aid volatility is around 40 times greater than the volatility in domestic revenues when expressed as a percentage of GDP. Furthermore, in spite of donor initiatives to ensure more stable levels of aid, volatility appears to have become more severe over the 1990s. Moreover, aid flows have tended to be procyclical, and have thereby exacerbated the effects of volatility in domestic revenues. Aid flows have generally increased when domestic revenues are strong and fallen back when domestic revenues are weak.

Given the magnitude of aid volatility and unpredictability it would be expected that there would be an impact on public expenditure. The evidence on the instability of public spending on health suggests that this is probably the case. Figure 6 shows public expenditure on health over the period 1998–

Figure 6 Volatility in public spending on health in selected African countries



Source: World Health Report (2005). Public expenditure includes aid financed expenditures



2002 for six African countries. These examples are broadly representative of the patterns observed in low income countries. The chart shows that there are significant differences between countries. For example, Burundi and Ethiopia have managed to maintain fairly stable health budgets. However, volatility has been substantial in Benin, Malawi, Togo and Zambia, where variations in health expenditure from one year to the next have often exceeded 0.5% of GDP.

An association between volatility in aid and volatility in public expenditure on health can be demonstrated, although this does not prove causality. The results of a bivariate regression analysis are shown in figure 7, which plots volatility in net aid disbursements against volatility in public expenditure on health for 56 low income countries for the period 1998-2002<sup>12</sup>.

The results demonstrate a positive and statistically significant relationship between aid volatility and volatility in public expenditure in health. The R-square value indicates that 20% of the volatility in public expenditure is explained by volatility in aid. In addition, figure 8 shows that the volatility of public expenditures on health tends to be greater in more aid dependent countries.

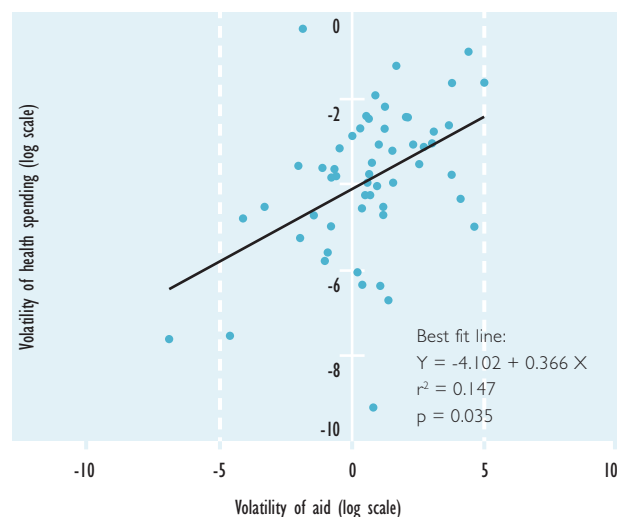
These findings provide some interesting insights into the effects of aid volatility and unpredictability on fiscal behaviour and fiscal space. In principle, governments can cushion the effects of short term volatility by temporarily drawing on reserves or by borrowing. However, the above observations suggest that governments have not been able or willing to cushion fully the effects of aid volatility. The most

likely explanation is that many low income countries are bound by conservative budgetary rules that force them to cut back expenditures if aid does not arrive. Many countries operate cash budgets that restrict borrowing and make it impossible to spend resources that have not yet been received. A common practice is to issue a hastily prepared supplementary budget after aid monies have arrived. Volatility will therefore have an immediate effect on fiscal space, and the level of public expenditure is likely to respond rapidly to fluctuations in aid receipts.

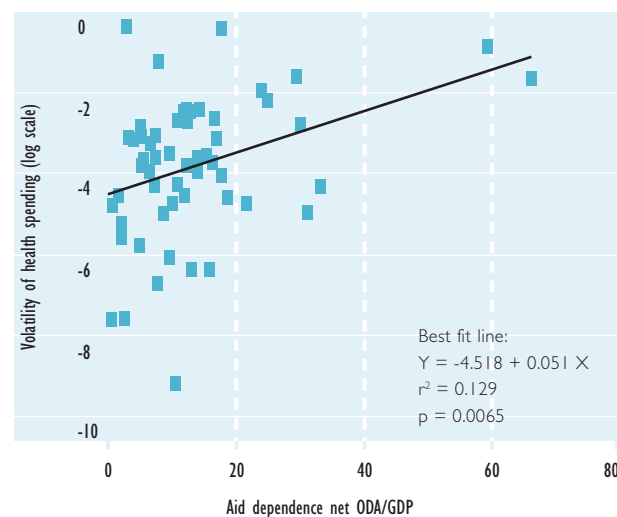
Volatility in health expenditures is likely to have a negative effect on service delivery. When governments experience sudden budgetary shortfalls difficult decisions must be taken on which expenditures to cut. The burden of adjustment tends to fall on more discretionary types of expenditure, such as drug purchases and new investment, rather than non-discretionary expenditures, such as salaries. This has been a common problem across the developing world where health workers are often unable to deliver services because of the lack of operating and maintenance spending<sup>13</sup>.

Another effect of aid volatility may be to influence the allocation of resources between levels of health care. There is some evidence that there is greater volatility in expenditures on primary health care than at secondary and tertiary levels because primary health care tends to be more dependent on donor funding (World Bank, 2005). In addition, aid volatility is likely to result in the funding shortfalls for primary health care. If donors fund primary health care then governments are likely to reallocate their own resources to other uses, including

**Figure 7 – Volatility in public health spending is correlated with volatility in aid**



**Figure 8 – and is greater in more aid dependent countries**



Sources: World Health Report (2005), OECD DAC database, World Development Indicators (2005)

higher level health care. When there is a shortfall or delay in donor funding, governments find it difficult to shift their own resources back into primary health care<sup>14</sup>.

Aid volatility and unpredictability may also have longer term effects on fiscal space and public expenditure. If governments cannot be confident that committed donor funds will arrive or that existing donor funded programmes will continue for more than a few years, they may understandably be reluctant to increase expenditures on areas that generate long term recurrent spending obligations. Where aid is volatile and unpredictable an increase in aid may not generate a proportional increase in sustained health expenditures.

These arguments assume special importance in the context of a substantial scaling up of aid. There is a risk that the problems of volatility and unpredictability may become even more severe when aid is scaled up. In addition, it may be difficult to persuade recipient governments to make ambitious plans for the expansion of health services unless donors can instil greater confidence that increased aid will materialise and that higher aid volumes will be sustained over the medium to long term. In the light of past experience fiscally prudent governments would have good reason to discount donor promises to scale up aid. They may be particularly reluctant to use risky aid funds to finance long term recurrent health expenditures. The case of anti-retroviral therapy is a well known example of the dilemma facing aid recipients. While many governments are under great pressure to expand these programmes, current forms of aid may be too unpredictable and unstable to finance the required lifelong treatment programmes. The consequences of budgetary cuts in these programmes would be catastrophic because interruptions in anti-retroviral therapy reduce the benefits of treatment to individuals, and may lead to the emergence of more resistant strains of the virus that would reduce the effectiveness of treatment for everyone.

It is difficult to generalise about how recipient governments will respond to these problems. Some governments may react to increases in aid in a fiscally prudent manner, and increases in health expenditure will be relatively restrained. Other governments, taking a short term view, may be inclined to spend unpredictable, lumpy aid receipts on projects that have unaffordable recurrent cost implications. Either way the outcomes will be sub-optimal.

## **b. Aid coordination, harmonisation and alignment**

Aid should not be viewed as a single category, but rather as a diverse and fragmented set of resource flows. In most low income countries there is a proliferation of donors using many different types of instruments to manage their funds. Proliferation is perhaps most extreme in the health sector. Foster states that: "The health sector has more active donors involved in more individual activities than any other sector, and the problems are getting worse, with the recent addition of significant new sources of funding." (Foster, 2004, p 68).

The fragmentation of aid should be viewed as a constraint on fiscal space for two main reasons. The first is that donor aid is only partly integrated into recipient government budgets. Around half of donor aid is provided off-budget, and is used to provide technical assistance or to fund NGO projects. These resources will only create fiscal space where there is scope for fungibility. However, the extent to which off-budget donor spending will free up government resources to be used elsewhere is quite limited. Even where aid is accounted for in government budgets, the majority is provided for donor managed projects. Again, there may be scope for fungibility, but the increase in fiscal space will be less than if the government could exercise full discretion over the use of donor funds. The only category of aid that is on-budget and under the full control of recipient governments is general budget support. However, only a small part of aid is provided in this form. A recent analysis of aid relationships in 14 developing countries revealed that only 20% of donor aid was provided as general budget support (Foster, 2004).

The second reason why the fragmentation of aid constrains fiscal space is that the proliferation of projects imposes major efficiency costs. There is a substantial waste of resources resulting from management duplication, weak coordination and the establishment of parallel planning and management structures. Projects are often not well integrated into national health systems, and in the worst cases may undermine these systems by depriving them of staff and resources. Project aid tends to result in unbalanced patterns of spending, and makes it very difficult for governments to prioritise spending in pursuit of a coherent strategy. Recipient countries also face a significant administrative burden managing multiple relationships with donors. All of these inefficiencies waste public resources and thereby deprive governments of fiscal space.

The above arguments suggest that providing a greater share of donor resources in the form of budget support would have a positive effect on fiscal space, and would improve aid effectiveness more generally. In the context of scaling up aid, this may be the only viable option to increase funding without overstraining domestic administrative capacity. However, the shift towards budget support may not necessarily result in increased public expenditure on health. Although the evidence on this point is limited, one recent study of Tanzania indicates that following the start of budget support in 2001 there has been an increase in public expenditure on health in per capita terms, but the share of health spending in the budget has remained unchanged (Lawson *et al.*, 2005). This example indicates that there is no reason to expect that budget support will result in changes in public expenditure allocation.

In general budget support will only generate higher public expenditures on health where governments and donors share a common preference for higher health spending. There is no guarantee that this will be the case. Donors typically earmark budget support for use in certain sectors, but such conditions may not be respected where governments have different spending priorities. In some countries budget support will not be an appropriate aid instrument; in particular where donor and government priorities are very different, and where there are poor standards of public financial management and accountability. Under these conditions there may be a case for providing off-budget project aid or channelling support to non-state actors. However, this approach will not prevent fungibility, and may not result in higher health spending than if aid had been provided on budget.

There is a risk that the inefficiencies caused by the fragmentation of aid delivery will get worse as aid flows increase. However, recent trends indicate a gradual shift away from project aid towards budget support (DFID, 2002). This has been associated with the provision of debt relief and Poverty Reduction Support Credits in the context of PRSPs. In the health sector the Sector Wide Approach (SWAP) has become an important form of aid delivery that has provided a basis for improved donor coordination and the alignment of donor funding in support of a government-owned policy and expenditure framework<sup>15</sup>. However, this approach has so far been limited to a relatively small number of countries.

The Paris Declaration on aid effectiveness is an important signal of donor commitment to address

problems of aid coordination, harmonisation and alignment. Discussions are currently underway to set targets for improvements in several aspects of aid management and delivery, including reporting aid on budget, increasing the proportion of aid provided as budget support, improving aid predictability, untying aid procurement rules, avoiding the use of parallel systems and deploying joint country missions. All of these objectives, if implemented, should help to maximise the fiscal space created by additional aid flows.

The major exception to the general trend towards improved aid coordination, harmonization and alignment has been the growth of global health initiatives, for example GFATM, PEPFAR, GAVI and philanthropic foundations funding health programmes. There has been a particularly dramatic increase in funding for HIV/AIDS, most of which has been provided through global initiatives, rather than from the traditional sources of bilateral and multilateral aid. In several countries external funding for HIV/AIDS is already equivalent to or greater than the public health budget<sup>16</sup>. The majority of funds distributed by the global initiatives has been provided off-budget, and has been channelled through parallel structures, often to projects implemented by NGOs or private contractors. This strategy reflects the urgency of responding to global health emergencies, and the weaknesses in the capacity and governance of national health systems. However, there are concerns that stand-alone HIV/AIDS programmes may undermine the ability of governments to develop well functioning, integrated and sustainable health systems. The large scale funding available for HIV/AIDS will inevitably draw human and financial resources out of national health systems, weakening their capacity to respond to other health priorities (Lewis, 2005). There are also more general concerns that insufficient attention has been given to the long term financial sustainability of HIV/AIDS programmes as discussed above.

## 5. How does recipient behaviour affect fiscal space and sustainability?

While donor behaviour has an important influence on fiscal space, recipient government policies determine the key variables that establish fiscal space: growth, revenue effort and the allocation of public expenditures. This section discusses two important challenges that need to be addressed by aid recipients in order to create fiscal space for health spending,

and to utilise it effectively. These are concerned with: (i) allocating resources to their most productive uses, (ii) strengthening absorptive capacity.

### **a. Ensuring productive use of expenditures**

In the long term the main source of additional fiscal space will be economic growth. There is no other way to achieve the sustained increase in domestic revenues that will be required to fully finance MDG goals in low income countries. It is therefore very important that public expenditure is spent in productive ways that, first, improve health status, and, as a result, generate accelerated economic growth. From the perspective of this paper there are two crucial issues: (i) the allocation of spending between the health sector and other sectors, and (ii) the pattern of spending within the health sector.

In principle, decisions on the sectoral composition of public spending should be guided by evidence on social returns. Unfortunately, there is great uncertainty about the rate of return on spending in different sectors, in particular in the health sector. There is considerable debate about whether higher public expenditure on health results in improved health outcomes in low income countries. While some econometric studies find a positive relationship between public expenditure and health, others find no statistically significant relationship (see Roberts, 2003 for a review of these studies). More recent studies have found stronger evidence of a link between public expenditure and health indicators, in particular in relation to the benefits of immunisation which seems to be particularly sensitive to differences in government health expenditure. For example, Rajkumar and Swaroop (2002) find that higher public expenditure on health lowers infant mortality rates in countries with good governance. Bokhari *et al.* (2005) find a statistically significant relationship between public expenditure on health and the under-five and maternal mortality rates. However, all of these studies show that the effect on health of higher public health spending is relatively small.

Despite important exceptions<sup>17</sup>, most studies find that health outcomes are more strongly determined by variations in income levels than variations in public spending on health. Roberts (2003) reports that around 75-80% of the variations in health outcomes between countries are explained by differences in GDP per capita (Roberts, 2003). Higher levels of income provide many types of social benefit that result in improved health, for example improving

living standards, better education and delayed age of first pregnancy. Moreover, growth is essential to generate the domestic resources that will be required to finance future improvements in health services. However, this should not imply that governments should invest all of their resources in fostering growth rather than improving health services. Important health problems can and do persist even in rapidly growing economies, for example high maternal mortality. In addition, the relationship is two way: improvements in health indicators will also stimulate growth. While the evidence base is incomplete, there are a number of studies that purport to establish a causal link between better health, greater productivity and economic growth. All of these arguments suggest that neither growth nor public spending alone will be sufficient to improve health outcomes. Improving health in low income countries will depend on both of these factors.

It is not the purpose of this paper to enter into the complexity of the debate about the health impacts of public expenditure. However, from the perspective of fiscal space a number of observations can be made that may help to guide decision making on the share of public expenditure allocated to the health sector.

- There will always be a great deal of uncertainty about economic returns to health spending, in particular the financial and taxable returns. Furthermore, there is likely to be a significant time lag between public investments in health and the timing of economic benefits. In view of these uncertainties, which are not unique to the health sector, the usefulness of evidence on rates of economic or social return in guiding spending decisions is questionable. However, further research may help to strengthen the evidence base.
- Rates of return to health spending will vary between countries. Much depends on the quality of governance and the effectiveness of health systems in delivering basic services. In countries with better functioning health systems higher public expenditures will result in greater improvements in health indicators. In countries with poorly functioning health systems, the returns on higher spending may be close to zero. In these countries the immediate focus should be on reforms to improve service delivery efficiencies and equity. Improving providers' incentives, particularly to care for poor people, and removing



incentive distortions are at the heart of improving the returns to additional public expenditure on health. This will include improving governance, building capacity and strengthening management, as well as exploiting the comparative advantage of different types of provider. Radical rethinking may be required on the public role in health and the structure of the government health workforce.

- At the level of individual countries it is possible to make informed judgements about the cost of expanding access to essential health services. Such information provides a more practical basis for health budgeting than cross country evidence on rates of return to health spending.
- It is important to ensure that resources are available for complementary investments in other sectors that contribute to improved health outcomes. For example, investments in transport infrastructure may be required to improve access to health services.
- The opportunity costs of increased public expenditure on health need to be considered. It would not be desirable to crowd out expenditures in other sectors that may have a stronger and more immediate impact on growth than health spending.
- It must also be recognised that the benefits of public spending on health should not be viewed solely in terms of economic returns. As highlighted by the Millennium Development Goals improvements in health indicators are a benefit in their own right. Furthermore, public spending on health can provide an important safety net for the poor, partially protecting them from the risk of incurring catastrophic medical costs.

The common wisdom is that in many low income countries public expenditure is misallocated within the health sector. The bulk of health budgets in low income countries has tended to be directed at secondary and tertiary health facilities offering curative services that mainly provide private benefits to small numbers of people. Primary healthcare has tended to be a lower priority, and there has been a particular tendency to under-fund promotional, preventative (such as the control of communicable diseases) and environmental services that generate public goods, such as a safer health environment, that benefit everyone, but that individuals are unwilling to pay for. A reallocation of public expenditure towards primary health care may be justified both on equity and on efficiency grounds provided there is also a way of funding the catastrophic

costs of secondary and tertiary care for poor people. The empirical evidence for the appropriate balance is limited. In many low income countries, for reasons discussed above, neither primary nor higher level care is properly financed.

Although improvements in the allocation of public expenditure may be desirable, political pressures often prevent reform. Political elites and non-poor urban groups, who have a stronger political voice, tend to focus their demands on subsidies for secondary and tertiary health care. Medical staff often form an influential lobby group, who tend to call for the expansion in the provision of higher level health care because of the greater incentives that this provides in terms of salaries, career advancement and the official and unofficial fees paid by patients. There are few organised interest groups advocating greater provision of preventive and primary health care because the benefits tend to be more dispersed. This makes a just and efficient allocation of the government health budget between levels of service all the more difficult to achieve.

In the context of scaling up aid there is a particular risk that the additional resources will be misallocated or used wastefully. When resources are more abundant, it is harder for governments to withstand pressures from unions and special interest groups. More generally, it may become more difficult to maintain discipline in spending decisions and to deny funds for bad projects. This underlines the importance of strengthening systems of public expenditure planning and management, budget monitoring and public accountability as an essential condition for scaling up aid.

## **b. Absorptive capacity**

The debate about scaling up aid has also highlighted the question of whether recipient countries have the capacity to absorb large increases in aid flows. The term absorptive capacity is not precisely defined, but is commonly used to refer to the policy and institutional constraints that prevent additional funds from being used effectively. These include the weakness of budgeting systems, failures in public administration, shortages and mismanagement of human resources and skills, and broader governance failures, including corruption.

There is some debate about whether absorptive capacity is a constraint on fiscal space (Heller, 2004). In a strict sense fiscal space is determined by resource availability rather than by absorptive capacity. However, absorptive capacity constraints may mean that



governments cannot effectively utilise additional fiscal space. In the context of scaling up aid, absorption constraints may generate increasing inefficiencies and waste. Where aid resources are not invested productively opportunities to generate fiscal space through economic growth will be missed.

It is difficult to generalise about absorptive capacity constraints because the problems vary among countries and between different types of expenditure. Some types of expenditure are amenable to rapid scaling up, for example the purchasing of drugs and the extension of free service provision. Funding can also be used to address certain capacity constraints. For example, low public sector wage rates and low government sector productivity characterise many health systems in low income countries. Additional funding for staff recruitment and salary increases might address these human resource constraints and problems of low levels of motivation among health workers that undermine the performance of public health services. However, there is a risk that this would lead to demands for wage increases across the public sector, generating broader pressures on fiscal space. Moreover, increased pay alone is unlikely to generate productivity gains. Fundamental employment, pay and management reforms are almost certainly required to ensure that enhanced fiscal space is translated into better quality health services.

The most difficult absorption problems usually relate to concerns about governance, public accountability and the risk of corruption. There are often very serious weaknesses in planning and management capacities that prevent resources being delivered 'on the ground', where they are needed. Public institutions often fail to provide incentives to use resources efficiently and to respond to user demands. Where oversight and financial controls are lacking there is a serious risk of corruption<sup>18</sup>. To a certain extent technical assistance funded by donors can help to improve systems of public sector management. However, in most cases there is a need for broad ranging public sector reform, which will depend more on high level political commitment than on donor aid.

A recent study of health financing in 14 countries found that many types of absorption constraint could be addressed through well targeted funding and technical assistance. However, the weakness of governance and public sector management was found to be a serious absorption constraint in several countries. In two countries (Tajikistan and

Cambodia) governance and expenditure management constraints were judged to be so pervasive that major reforms would be needed to precede or accompany increased funding. In another two cases (Benin, Burkina Faso) government procedures were found to be over-centralised and bureaucratic, and in need of reform in order to permit available funding to be spent (Foster, 2004).

## 6. Macroeconomic effects of scaling up

It is increasingly recognised that aid inflows have significant macroeconomic effects, particularly in low income, aid dependent countries. There is a concern that large increases in aid could result in appreciation of the real exchange rate (Dutch disease) and tighter monetary conditions that would hurt the private sector and, in particular, producers of tradable goods. These risks may impose limits on fiscal space and the extent to which higher aid flows can be spent without undermining growth. This section discusses the macroeconomic effects of aid in general, as well as specific arguments that apply to the health sector.

There are essentially two macroeconomic risks associated with scaling up: (i) real exchange rate appreciation, and (ii) crowding out of the private sector. The first risk arises because higher expenditures financed by aid may increase demand for non-tradable and tradable goods. Where the demand for non-tradable goods cannot be met from spare capacity the price of non-tradables relative to tradable goods will increase, and the real exchange rate will therefore appreciate. The second risk occurs where governments try to avoid these inflationary effects by restraining demand, usually by tightening monetary policy. Higher interest rates reduce private sector borrowing and thereby constrain private sector demand. In this case aid creates fiscal space for government spending, but only by taking space away from the private sector. The extent of crowding out depends a great deal on whether or not there is spare capacity in the economy.

Both of these effects have been observed in low income, aid dependent countries. Real Exchange Rate appreciation has been observed in Uganda (Adam and Bevan, 2003) and Tanzania (Kweka et al., 2005) during the late 1990s at a time of increasing aid inflows. No such effect has yet been observed in Ethiopia, but macroeconomic modelling of the effects of scaling up suggest that Dutch disease could occur in future under conditions of higher

aid flows (Andrews *et al.*, 2005). In Tanzania there is evidence of a sharp reduction in private sector credit since the mid 1990s coinciding with a period of higher aid inflows (Kweka *et al.*, 2005).

There are two main ways that aid can be used in order to avoid these macroeconomic risks. First, aid can be used to improve economic productivity and thereby relieve capacity constraints. Second, aid can be used to finance imports, in which case there is no effect on domestic demand. There are reasons to believe that both of these effects might be observed in the use of development aid for health, in which case the macroeconomic risks would be limited.

The productivity effects of health spending have been discussed in section 4.1. Although the evidence on the economic returns to health spending is unclear, there is potential for aid financed public expenditures on health to raise labour productivity and thereby create additional capacity in the economy. However, these benefits would not be immediate. In the short term higher public expenditures may create demand pressures before the additional capacity can be created.

It has been suggested that a large proportion of development aid for health would be spent on imports. The Commission for Macroeconomics and Health estimates that the import content of required additional expenditures could be as high as 50% (Commission for Macroeconomics and Health, 2001). However, the Millennium Project has estimated that the local cost content of additional expenditures required to achieve the health MDGs would be around 70-75% (Millennium Project, 2005). Much depends on which additional goods and services will be provided. For example, the large scale expansion of ARV treatment programmes would require low income countries to import substantial quantities of drugs<sup>19</sup>. However, there are good reasons to expect that the majority of additional health expenditure would be spent domestically. Health workers' salaries are likely to absorb a substantial share of additional spending. Furthermore, the type of interventions that would be required to reduce child and maternal mortality would appear to be local cost intensive because they mainly require simple technologies combined with significant human resource inputs.

These arguments suggest that there is nothing special about public expenditure on health that will reduce the macroeconomic risks of higher aid flows. Substantial increases in public expenditure,

for health, inasmuch as it is spent on government-provided, rather than privately-provided services, will shift demand from the private to the public sector. In many cases such increases in spending may be justified, especially where this produces public goods and generates the human capital that will be required to enable stronger private sector-led growth in future, albeit after some time. However, the impact on private sector investment and consumption should always be considered. At a certain level of public spending the marginal costs of additional expenditure will exceed its marginal benefits. This constitutes an upper limit to fiscal space that no government should exceed irrespective of the amount of aid on offer. It is difficult to establish where this limit lies. However, most would argue that the poorest countries are some way from reaching this limit. With careful economic management to ensure that scaled-up aid supports improved service delivery as well as growth, fiscal space can still be expanded.

## 7. Conclusions

The general conclusion of this paper is that the potential to use aid to generate sustainable fiscal space for substantial increases in health expenditures in low income countries depends crucially on the way aid suppliers and its recipients manage additional aid flows. Combinations of donor and recipient behavior will determine how effectively and durably additional aid will expand fiscal space. Some of these are summarized in the table 3 below. The best combinations suggest that fiscal space can be expanded quickly and reliably ('Green Zone'); the worst that great caution should be exercised until reforms have shown signs of success ('Red Zone')

### Main priorities for aid donors

*Ensuring longer term predictability of aid flows*  
Donors have signaled their intention to increase aid flows substantially, but recipient governments are faced with a great deal of uncertainty about the level of support that they can expect in future. On the basis of past experience, recipient governments may be reluctant to increase health expenditures, especially where new spending implies long term recurrent expenditure commitments. Unless donors can provide longer term commitments and more predictable aid flows, additional aid may not generate much additional fiscal space for health spending.

**Table 3 Conditions for the sustainable expansion of fiscal space**

	Donor policies	Recipient policies
<b>Green Zone</b> Far reaching changes in donor and government behaviour allow fiscal space to be expanded rapidly and sustainably	Donors are able to make long term commitments to scale up aid	Governments have affordable long term investment and expenditure plans
	Donor aid flows are predictable and stable	Increase in aid is accompanied by a stronger tax effort
		Governments are able to finance any residual cash-flow variations
	Donors are able to coordinate and harmonise aid, and thereby reduce recipients' transactions costs	Governments are able to take responsibility for the management of donor aid, and bring it on budget
		Where justified, governments reallocate budgets in favour of the health sector
		Government health systems are efficient, effective and equitable
<b>Amber Zone</b> Partial reforms in donor and government behaviour allow some increase in fiscal space, but problems of sustainability remain	Some progress in increasing the long term predictability of aid and reducing short term volatility.	Governments may take on new spending commitments that cannot be sustained
	Some initiatives to improve donor coordination and harmonisation, but limited use of budget support.	Governments do not improve their revenue effort
		Governments are unable to fully finance cash-flow instabilities
		Public expenditure management systems are not yet robust enough to account for aid expenditure on budget
<b>Red Zone</b> Great caution should be exercised in raising health expenditure until reforms in donor and government policies show success	Donors are unable to make long term commitments or reduce aid flow volatility	Very weak public expenditure management
	Aid remains highly fragmented and projectised.	Donor spending remains largely off-budget
		Governments do not improve their revenue effort
		Health care providers are not well motivated or managed
		The poor do not benefit from public health expenditure

### *Reducing short term aid volatility*

This paper has highlighted the extent of aid volatility and has demonstrated that this is associated with significant instabilities in public expenditures on health. These, in turn, distort resource allocation and have negative consequences for service delivery and health outcomes. The risks of short term volatility may provide an additional reason for governments to be wary of budgeting on the basis of additional aid resources. Donors need to address the risk that scaling up aid will generate even greater volatility and more disruptive effects.

### *Coordination, harmonization and alignment*

Uncoordinated, off-budget and projectised aid contributes little to durable fiscal space. Aid effectiveness would be increased if aid coordination was improved, and the alignment of donor funding with national priorities were strengthened. Where conditions allow, the greater use of budget support would be desirable. There are encouraging signs of improved donor practice, including the recent Paris Declaration. However, there are contradictory tendencies in the health sector, where an increasing share of aid is provided through global health

initiatives that tend to operate through parallel structures outside government budgets and management systems.

## **Main priorities for aid recipients**

### *Ensuring fiscal sustainability*

Ensuring the fiscal sustainability of health expenditures will be a major challenge for recipient governments, particularly low income countries facing ‘windfall aid incomes’. There is a risk that some governments will make capital investments that they cannot fully maintain, take on too many staff to pay properly, or take on other new spending commitments that prove to be unaffordable and unsustainable in the long term. On the other hand concerns about the unpredictability and unreliability of aid flows may cause some governments to be overly cautious about using additional aid to augment health expenditures financed from domestic resources. The key to ensuring fiscal sustainability is for recipient governments to take a long term view of expenditure commitments, growth and mobilizing domestic revenues.

### *Using aid productively*

In the long term the main source of additional fiscal space will be economic growth. It is therefore crucial that recipient governments use aid in productive ways. Careful judgements will need to be made on the allocation of public expenditure between and within sectors taking into account the best available evidence of the impact of public expenditure on human development and economic growth. The central challenge will be to improve the efficiency of health systems to ensure that higher spending will generate improved health outcomes. In many cases reallocating resources within the health sector

towards primary health care would improve efficiency and equity.

### *Addressing absorptive capacity constraints*

Important capacity constraints arise from organizational, managerial and governance weaknesses, which may reduce the returns to additional aid and public expenditure substantially. In these conditions it will be important to scale up aid at a measured pace, and to accompany this with institutional and governance reforms to create conditions where aid can be used effectively.

### *Taking account of the macroeconomic effects of higher aid inflows*

There are macroeconomic risks associated with scaling up aid, in particular real exchange rate appreciation and the crowding out of private sector investment. Development aid for health is no different to other types of aid in this respect. In many cases it will still be justified to increase donor support to the health sector, in particular where this supports expenditures that provides the public goods and generates the human capital that will be required to enable private sector-led growth in future. However, the impact on private sector investment and consumption should always be considered. At a certain level of public spending the marginal costs of additional expenditure will exceed its marginal benefits. This constitutes an upper limit to fiscal space that no government should exceed irrespective of the amount of aid on offer. It is difficult to establish where this limit lies. However, most would argue that the poorest countries are some way from reaching this limit. With careful economic management to ensure that scaled-up aid supports both improved service delivery and growth, fiscal space can still be expanded.

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# FISCAL SPACE AND SUSTAINABILITY: TOWARDS A SOLUTION FOR THE HEALTH SECTOR

By Mick Foster, Paris, November 2005



## Executive Summary

Reaching the MDGs in low income countries will require substantial increases in public expenditure that can only be financed with much higher development assistance sustained over many years. Donors have responded by promising big aid increases, with global aid expected to increase by over 60% between 2004 and 2010 while aid to Africa is expected to double. The fundamental problem addressed in this paper is that donor commitments to individual countries remain short-term and highly conditional and do not come close to reflecting these global promises of increased aid, while donor disbursement performance remains volatile and unreliable. Governments are therefore understandably reluctant to take the risk of relying on increased aid to finance the necessary scaling up of public expenditure. The paper discusses options for addressing five issues that are critical to tackling the problem. The options, and their advantages and disadvantages, are summarised in a matrix table after this Executive Summary (Table 1). References are to lines in the table.

### Issue 1: What can be done to encourage governments to reflect donor promises of increased aid in their expenditure plans?

Recipient country governments need to believe that donors will increase aid and maintain it at the higher level before they will assume it in their expenditure plans. At present, countries tend to include only formal donor commitments in their budgets and Medium Term Expenditure Frameworks (MTEFs), and countries such as Uganda discount even formal commitments reflecting the past experience of incomplete and delayed disbursement.

Ideas under discussion internationally mainly focus on making the promised increase in **global** aid more certain, and less dependent on annual donor budget allocations (1.5). Proposals for financing increased aid include borrowing on international capital markets (the proposed International Financing Facility, IFF), hypothecating taxes on air travel,

selling IMF gold, or making a special issue of IMF Special Drawing Rights (SDRs). These ideas will be difficult to negotiate and will be of only limited help to a Government wishing to know how much aid it will receive. More secure global aid could be used to make longer term country commitments, but at present the global figures have not been allocated to individual countries.

One way to give countries assured long-term access to increased aid is by providing the funding in advance and irrevocably. Debt relief is the only form of irrevocable long-term funding that has been used on a large scale in developing countries (1.1), but it cannot provide sufficient support to some of the countries of greatest concern. Other forms of payment in advance have been proposed, but are not attractive to donor countries that have their own budget constraints, and wish to retain some leverage on the future behaviour of aid recipients.

The obvious way to change recipient government assumptions about future aid levels into line with donor promises is for donor agencies to make long term commitments setting out their intended level of aid to each country (1.2). A rolling forward pipeline of five to ten years, combined with assurances that adjustments beyond that date would be at a moderate pace, would probably give sufficient assurance, if the commitments could be believed. Confidence in commitment and disbursement promises might be improved by transparent donor reporting, with explicit advice on the nature of the risks of under-disbursement.

Unfortunately, long term commitments of future aid are difficult for many donor governments, who face legislative constraints, and cannot commit their successors (1.2). Donors also wish to retain some flexibility to react to events, and are reluctant to tie up a significant share of their budget in long-term commitments. Even multilateral agencies reward staff more for eye catching new initiatives than for sound management of existing commitments. Although some bilateral donors have given long-term indications of support, these are less binding

than formal commitments, and have in practice been subject to interruption due to policy differences and governance concerns. The most that is currently on offer from individual donors is non-binding assurances of 'best efforts' to maintain aid beyond the medium term, which is not a secure foundation for financing a long-term commitment to higher public expenditure.

Collective donor assurances, with the donor group as a whole undertaking to ensure that the required level of external finance is forthcoming, have been tried, but with only limited success (1.4). It has proved difficult to mobilise additional funding in the amounts and at the times required to offset the impact of aid falling short of expected levels. Donor assurances are unlikely to be believed, given the past record of aid volatility and of disbursements falling short of commitments.

Donors have historically found it easier to make longer term commitments to specific expenditure programmes or projects (1.3). In cases where long-term obligations are incurred by a government as a result of donor urging, there can be a compelling moral case for guaranteeing that the funding will not be abruptly withdrawn. Anti-Retroviral Treatment for HIV/AIDS sufferers is the most important example, where ethical considerations require treatment to be maintained for the life of the patient. Commitments could also be made to a specific sector, or to a defined sub-set of the budget, such as the EC proposal to provide longer term funding to support government spending on the Millennium Development Goals.

Long-term commitments to specific programmes in a country could be conditional on the preparation of credible plans to achieve specific outcomes, and would need to be based on an understanding as to how the programme will be financed, and how it will be adjusted and rolled forward over time. This would provide a way to avoid a 'Catch 22' problem where aid is low because plans are un-ambitious, while plans are un-ambitious because of uncertainty over the aid available.

If there is no agreement on overall public expenditure priorities, *the risk to donors* is that the expenditure may not be additional, but will enable a government to redirect domestic revenues to other purposes such as defence. Donors can limit this risk by disbursing their aid for the specific programme on condition that government spending exceeds some threshold level. It is far more difficult to address the serious *risk to government* that aid allocated to a specific programme may not be

additional, and may distort spending priorities as donor funds are withdrawn from other areas. For example, a government spending just \$10 per head on health, half of which is donor funded, is unlikely to choose comprehensive HAART treatment unless it is confident that the resources to finance it are additional and do not reduce the aid available for basic health programmes. To minimise the risks to both sides, it is helpful if expenditures are part of an understanding on public expenditure as a whole, and how it will be financed from domestic and foreign sources. This takes us back to the need for longer term commitments of total aid to the government budget as the only way to ensure aid additionality.

If little can be done to extend longer term commitments to countries, there may at least be scope to help governments make realistic assumptions as to the aid they are likely to receive. Improved donor reporting, and the publication of improved long-term forecasts of global aid, would help countries to make realistic assumptions. This needs to happen in country, but the realism of country level assumptions could be improved by better international reporting and forecasting. Publication of commitment and disbursement data by donor would also help pro-aid lobbyists place pressure on individual donors to fulfil their promises. Governments can manage the uncertainty (and lobby for increased aid) by preparing more than one scenario, showing how extra aid would be used. However, none of these measures are an adequate response to the fundamental problem that it is risky to use short-term and volatile aid commitments to finance stable long-term expenditure obligations.

In addition to the discussions on measures to increase long-term aid, there has also been discussion on how to address the problem from the other side, for example by reducing the cost of procurement of medicines and other supplies by global subsidies and advance bulk purchase. This can have a significant and very positive impact by reducing the scale of the funding shortfall that needs to be bridged.

## Issue 2: How can longer-term commitments be reconciled with aid effectiveness?

There is a fundamental inconsistency between the long-term spending programmes that require support, and the short term conditionality used by donors to ensure aid effectiveness (2.1). Governments know what they must do in order to meet the terms of *current* aid agreements, but must gamble on

their ability to continue satisfying the donors through a series of future agreements, the terms of which are currently unknowable.

Abandoning conditionality entirely, in favour of a needs based 'entitlement' approach to aid allocation, would have the advantage that populations would not be penalised for the failures of their governments. However, the aid effectiveness literature suggests that such an approach would result in aid being wasted in environments where it can not be effective – though it is arguable that the negative effects of a weak environment might be somewhat reduced if aid is committed longer term and is available to address some of the recurrent cost constraints (2.2).

As an alternative, aid could be allocated based on a model that takes account of indicators measuring the quality of policy and institutions, and development outcomes, as well as needs. There would be no policy conditionality, but aid levels would respond over time to changes in the indicators, at a speed that a government can adjust to, with opportunities to discuss how a higher aid path could be re-established (2.3). The Country Policy and Institutional Assessments (CPIA) already produced by the World Bank could perhaps be developed as the basis for such a system. The approach could be applied by individual donors in respect of their own aid, or could be the result of agreement between donors, possibly with a lead donor agency such as the World Bank identifying and publicising aid requirements, and itself acting as a 'swing donor' to offset biases in global aid allocation. If performance declines, aid cuts would be pre-announced, introduced slowly and based on explicit criteria. Any cuts would also be accompanied by dialogue on how a higher aid path might be re-established.

The advantage of such an approach would be greater certainty about aid in the medium-long term, and reduced risk of short-term volatility. If the indicators include a stronger focus on outcomes, the approach would also improve country ownership, by allocating aid more on the basis of what it is achieving rather than whether a government agrees with the donors. The swing donor role could also help to improve the quality of aid, since countries would have less incentive to accept aid with strings attached if any shortfall is likely to be made up by other donors. The approach would require investment in a robust and credible indicator framework. Such an approach will not prevent donors reacting quickly to political or governance concerns,

though greater transparency might help to ensure that misunderstandings do not cause avoidable aid suspensions (2.6). The proposed 'swing donor' role might, however, provoke objections from bilateral donors reluctant to see the results of their bilateral allocation decisions undermined.

If the main concern is to achieve and sustain the MDGs, funds could be allocated to specific sector or sub-sector programmes, with only sector-level conditions (2.4). Long-term programmes need to adapt to changing circumstances, and longer-term conditions would need to focus on process (how future decisions will be made) rather than seeking to specify the policies and spending programme in detail. There would be a graduated response to poor performance or policy disagreements:- analysis, dialogue, and more restrictive conditions for access to aid would be the first recourse, with reduced commitments or partial suspension only in extreme cases. The approach requires a high measure of mutual trust, though the experience of the longer-running Sector Wide Approaches suggests that it may be workable, if all partners are prepared to work through disagreements. As with the overall aid allocation model, aid funding would maintain a medium-term pipeline of commitments, with spending adjusting slowly to changes in sector performance, and with an implicit donor commitment to continue supporting the sector into the long term future (2.5).

### **Issue 3: Should external aid support the government plan?**

There needs to be a single overall policy and planning framework for public expenditure on health, although that plan may allow for diversity of funding and of service providers, may be very decentralised, and may include a range of experimental and pilot projects. The importance of an overall framework, however, is to prioritise interventions that have the largest positive health impact for the funds allocated, and to minimise inequalities in what services are available, and who has access to them. Aid that is used to fund expenditures that are outside the government plan may displace spending that the government would have preferred. They will normally have lower ownership and be less sustainable, and will often be of lower value for money than the planned activities they displace. If the aid is additional to existing public expenditure plans, and on a large scale, it may have implications for the macro economy, potentially squeezing out private sector

spending, especially if expenditure is on local costs. These considerations carry less weight in fragile states, where donors carry more responsibility for co-ordination.

#### **Issue 4: How can the costs of aid volatility be reduced?**

Although the lack of long-term commitments is the more fundamental problem, the high volatility of aid flows poses problems for short-term macro-economic and budget management. Volatility in project disbursements does not cause a financing problem, because the funds and the subsequent expenditure usually move together. Volatility may require attention to building absorptive capacity, but does not create a financing problem. It is volatility in budget support that creates the problem.

Best practice approaches to budget support try to address the problems by medium-term indications of support, earlier commitment in time for budget preparation, disbursement early in the budget year, and reduced conditionality applied to the following year's commitment to avoid interrupting the current budget, with only a portion of funding at risk from policy failure in any one area of performance (4.1). None of these measures can prevent occasional interruptions due to political or governance conditionality, although efforts are being made to set out the issues of concern more explicitly, and to ensure through dialogue that both sides are informed of the likely impact of their decisions on aid flows.

Despite these measures, budget support remains very prone to interruption, because it is the easiest form of aid to cut, and (more positively) it is the easiest to increase when additional funds become available. It is therefore important to help governments to manage volatility, through full and accurate reporting and monitoring of aid flows, and by supporting active use of larger foreign exchange reserves for smoothing the impact on expenditure. The use of foreign exchange reserves for smoothing public expenditure is difficult because high reserves are a temptation to politicians who face spending pressures, while budget managers will find it hard to distinguish between temporary aid shortfalls that can be smoothed by drawing down reserves, and longer-term reductions that require adjustments to expenditure plans. Recognising that volatility cannot be eliminated, improved monitoring and increased use of foreign exchange reserves to manage budget fluctuations can be helpful in mitigating the consequences (4.2).

Volatility may be caused by absorptive capacity problems. Use of harmonised procedures based on existing processes of the recipient government, together with support to reform public expenditure management, can ensure that donors are not the cause of low disbursement (4.3, 4.4).

#### **Issue 5: How can countries insure against donor non-performance?**

These measures may not be sufficient to persuade governments to take the risk of relying on aid to significantly increase their public expenditure obligations. It is not enough for donors to ensure that the promises they have made will be delivered, they must also persuade partner governments that those promises can be relied on - a difficult task given the long history of volatile aid that falls short of promised levels.

In order to provide the required assurances, a DFID-funded study proposes the establishment of an Aid Guarantee Facility that poor and highly aid dependent countries could draw on if donors do not fulfil promises of increased aid. It could also be drawn on to slow any decline in aid in order to give more time to manage the consequences. The guarantee would be limited to budget and programme support, ensuring that aid shortfalls do not create financing gaps in the Government budget. The fund would not guarantee 100% of donor promises, but would limit the extent to which increases in aid fall short of expected levels, while ensuring that higher aid levels, once achieved, are not abruptly withdrawn. The effect of slowing the rate of decline will be equivalent to providing a longer term commitment with a slow taper from the peak, and could be an important additional assurance for finance ministers worried about the vulnerability of donor flows.

The cost would depend on the number of countries to be covered, the definition of the guarantee to be given, and the risk that donors do not fulfil their own promises. Establishing the fund would thus in itself be a declaration of seriousness on behalf of the donors. The risks would be managed by ensuring that there is transparency as to the causes of any shortfalls (to encourage civil society to lobby donors not meeting their commitments), with reviews of prolonged or heavy use. Access would be suspended in the event of catastrophic events such as major human rights abuses, but with an independent panel assessing the case for suspending access to give governments assurance that arbitrary decisions will be avoided.



The proposed fund would need to be used to smooth budget support as a whole. A specific fund for health would be difficult, given the problems of defining what portion of budget support assists the sector.

The proposal requires further study, but could be an important reinforcement of stated donor intentions to increase global aid. Fuller details are in section 5, and a response to the comments received on the proposal is at Annex 1.

**Table 1 Summary of problems and options for addressing them**

	Possible approaches to a solution	Benefits	Constraints and disadvantages
<b>1 Governments are assuming far less aid than donors have promised, leading to un-ambitious health &amp; other public expenditure plans that will fall far short of the MDGs.</b>			
1.1	Pay irrevocably in advance, e.g. through deeper debt relief.	Assured long-term flow of additional resources.	Does not reflect relative need, no redress if misused.
1.2	Longer-term donor commitments to support Government spending plans.	If commitments are believed, countries can plan and budget to meet long-term goals with more confidence.	Legislative constraints, inability to commit successors, reduced flexibility to respond to events.
1.3	Long-term commitments to specific spending programmes conditional on credible plans to achieve specific outcomes, joint review and decision taking.	Long-term commitment to specific MDG goals is easier to justify, allowing the co-ordination of ambitious plans and resources to implement them.	No guarantee that the aid, or the expenditure it finances, is additional, unless there is agreement on the overall budget and how it is financed.
1.4	Collective donor commitments to ensure financing gaps in approved programmes are met, 'swing donors' compensate aid orphans, offset short-falls.	If the collective commitment is credible, risks are reduced in implementing challenging spending plans and aid allocation improves.	Has not worked. Problems and delays in identifying need and mobilising resources, donors are reluctant to compensate for aid shortfalls that are deliberately imposed.
1.5	Make global aid less dependent on annual budget allocation: e.g. the IFF, the earmarking of aviation or other taxes to fund aid increases, IMF gold sales or SDR issue, longer-term multi-lateral agency funding.	If agreed, the probability of realising long-term donor commitment to increased aid rises.	Time consuming negotiation with uncertain prospects of success. May not help individual country predictability.
1.6	Produce global aid forecasts based on fuller reporting of donor intentions and performance to DAC.	Permits more realistic country planning. Helps civil society hold donors accountable. Identifies where aid should increase.	Closer monitoring may increase reluctance to commit. Requires judgement on realism of promises. Need to separately identify aid to individual governments.
1.7	Produce more than one aid scenario for PRSPs and sector plans, to show what extra aid could achieve.	Persuade donors to increase aid, by showing it can be well used. Helps prioritize.	Additional effort required may de-motivate staff if funding is not forthcoming.
1.8	Reduce the cost of procurement of medicines and other supplies by global subsidies and advance bulk purchase.	Reduces the scale of the funding shortfall that needs to be bridged.	Reduces the scale of the problem, but does not solve it.
<b>2 Governments need long-term funding, but donors need to ensure aid effectiveness</b>			
2.1	Current approaches: aid is short to medium term in nature, subject to frequent (usually at least annual) review and rolling forward.	Donors can cut aid if it is not used as agreed. Govt knows the minimum short-term conditions it must meet, but aid can still be cut for other reasons (e.g. governance).	Does not provide the assured long-term funding that is needed, because long-term aid levels depend not only on existing agreements, but on negotiating future ones.
2.2	'Entitlement': unconditional aid, based on need, sustained whatever the Govt does (though possibly via NGOs).	People not penalised for Govt failures, MDGs are pursued equally everywhere.	Ignores evidence that aid achieves less in difficult environments.
2.3	Aid allocation model: adjust aid over time to assessments of policy, institutions and outcomes, either by donor consensus or by 'swing donors' adjusting their aid to offset contrary trends by others.	Limits poor use of aid in medium term, while assuring the country that aid availability will change at a speed they can adapt to. Swing donor role helps drive out poor quality aid.	Use of CPIA-style indicators can not avoid some donor subjectivity – political upsets may still provoke aid cuts. Bilaterals may object to 'swing donor' offsetting the impact of their policies.



	Possible approaches to a solution	Benefits	Constraints and disadvantages
2.4	'Sector Blueprint' approach: Donors make specific commitments to finance a medium-term expenditure plan for a sector or sub-sector.	Specific inputs agreed in the MOU are guaranteed provided the programme is implemented as set out in programme documents.	Long-term plans need flexibility to adapt. Tends to favour investment rather than recurrent costs. Fragments budget management.
2.5	Longer-term (5+ years) commitments linked to rolling plan & joint institutional arrangements to achieve specific outcomes (e.g. related to a specific sector or MDG) <sup>1</sup> with assurances of continued funding in long-term (10+ years) if performance is OK.	Support depends only on sector progress, with graduated response to problems: analysis, dialogue, restrictions on use, lower commitments, and finally suspension of part of aid in extreme cases. Builds on SWAP best practice.	Long-term aid commitment may reduce pressures for reform. Requires mutual trust and commitment to joint decision-making. May distort spending priorities if not part of an overall agreement on budget and aid levels.
2.6	Greater clarity on donor political and governance concerns, and increased dialogue so decisions are made with knowledge of aid consequences.	Reduces a major cause of uncertainty and reluctance to increase aid dependence.	Donor political pressures over-ride formal agreements and cannot be controlled. There may be more scope for a systematic approach to multilateral aid.

### 3 Aid disbursements may be earmarked for expenditures outside the Government plan

3.1	Fill gaps in Govt PRS as first call on aid. Collective Govt and donor decision-making on spending priorities, including both financial and TA support.	Resources can be prioritised in support of sustainable plan to achieve the MDGs.	Govt and donor priorities may not coincide. In fragile states, donors may need to assume more co-ordination responsibility.
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### 4 Short-term aid volatility disrupts implementation of expenditure programmes

4.1	Best practice approaches: medium term indications of future aid, co-ordinate with budget preparation, disburse early, no interruption within the budget year; limit the share of aid that is subject to conditions on any one area of performance, active aid reporting, use Govt procedures.	More reliable planning basis for MTEF, earlier start to budget implementation, less disruption from delayed aid. Applying conditions to future commitments not current budget gives more time to adjust spending obligations. Avoids complete 'stop go'.	Donor commitment still short-term, not enforceable, depends on subjective assessment, and can be suspended for reasons not set out in the agreement. Danger of volatility in year t+1 if all donors reduce funding when e.g. IMF review is delayed.
4.2	Improve aid monitoring, use larger foreign exchange reserves to offset volatility, and prioritize spending to avoid across the board cuts.	Reduced cost of volatility.	Donors may resist use of aid for reserve build-up. Managing reserves is hard given spending pressures and uncertainty over duration of aid shortfall.
4.3	Improve Govt absorptive capacity: capacity building, decentralized management, public expenditure management reforms.	Can improve disbursement, and help motivate staff to deliver services.	Needs committed leadership to address motivation, overcome institutional rivalries. Time needed to train skilled staff willing to work in remote areas.
4.4	Donors use simpler, harmonized procedures based on those of Government.	Improves disbursement and aid effectiveness, releases Government capacity.	Institutional and political constraints for some donors.

### 5 Stronger assurances less dependent on continuing donor good will be needed to convince Governments to assume the risk of ambitious aid dependent expenditure programmes

5.1	Establish a facility to guarantee minimum ODA support to Govt budget in aid-dependent low-income countries.	Automatic access to a facility guaranteeing a floor level of aid greatly reduces the risk of using aid to finance higher public spending.	Relevance depends on first committing higher aid to countries. Needs design, appraisal and negotiation.
5.2	Sector guarantee fund.	A sector guarantee fund on broadly similar lines might prove easier to establish.	Hard to design a simple scheme able to address problems of fungibility and distorted priorities.
5.3	Include in the design a transparent and independent review process with representation from low-income countries to determine the appropriate response to fundamental political, governance or human rights issues.	Reassure donors that the facility will not support countries guilty of human rights abuses or egregious corruption, while reassuring Governments that aid will not be withdrawn without good reason.	Review panel and process needs to command the support of Govt and donors.

## I. Introduction

This study was commissioned by the High Level Forum to identify the issues surrounding the commitment and predictability of aid and its impact upon budget management in order to plan and implement a scaling up of health sector expenditure financed by additional aid and to map out the parameters of possible solutions.

In many low income countries, reaching the health MDGs will require an increase in public expenditure on health that is far beyond what can be financed from domestic sources – even on optimistic assumptions as to economic growth, resource mobilisation, share of public expenditure devoted to the health sector, and the effectiveness with which public health spending is used. The problems related to aid dependence are mainly concentrated in Africa, which contains all 12 of the countries where donor support finances more than 35% of total public health expenditures<sup>2</sup>. The Commission for Africa estimates an immediate requirement for an additional \$10bn per annum of donor support to health, on top of any increases in governments' own contributions, rising to an additional \$20bn per annum by 2015. Additional health spending represents 40% of the total increase in aid called for by the CFA, which advocates an additional \$25bn p.a. to Africa by 2010, with a further \$25bn by 2015, subject to a review of effectiveness<sup>3</sup>.

According to the OECD, the commitments of the G8 and other donors are broadly consistent with this. They are expected to lead to an increase of ODA to Africa by \$25bn by 2010, more than doubling aid compared to 2004 figures. The OECD estimates that official development assistance to all developing countries will increase from \$80bn in 2004 to nearly \$130bn in 2010<sup>4</sup>.

The majority of the incremental costs that need to be financed represent long-term recurrent cost obligations from which a government cannot easily exit without incurring substantial economic or political costs. Delivering the expanded package of health interventions needed to achieve the MDGs will require extra staff to be recruited, trained, and paid at rates that may need to be significantly increased in order to attract, motivate and retain them. Additional facilities from which outreach can be organised and services delivered imply incremental costs to operate and maintain them if the investment is not to be wasted. Obligations to treat HIV/AIDS patients require a life-time funding commitment, and in heavily affected countries the treatment

cost is already absorbing funding equal to or greater than the pre-existing total health budget<sup>5</sup>.

The problem is that governments in low income countries are understandably reluctant to embark on ambitious plans for expanding their health sectors without reasonable assurances that the funding is in place to sustain the expanded services.

This report discusses possible approaches to five questions that need to be addressed if governments are to rely on aid to fund the substantial increases in expenditure that will be needed:

- i. Governments are assuming far less aid than donors have promised, leading to un-ambitious health and other public expenditure plans that will fall far short of the MDGs. What can donors do to persuade Governments to base their plans and budgets on the higher aid levels that donors say they intend to provide?
- ii. How can the government need for reliable long-term funding be reconciled with donor requirements to ensure that aid is used effectively and can be withdrawn if governments misuse it or are guilty of human rights abuses or other behaviour that donors find unacceptable?
- iii. A large share of aid disbursements are used for expenditures that do not form part of government plans to achieve the MDGs and do not help to fill funding gaps. What are the implications for 'fiscal space', and what can be done to address them?
- iv. What can be done to reduce short-term aid volatility, and avoid it disrupting government expenditure programmes and undermining their effectiveness?
- v. Stronger assurances, less dependent on continuing donor goodwill may be needed to convince governments to assume the level of risk implicit in ambitious aid-dependent programmes. How might such assurances be given? The paper summarises proposals in an earlier DFID-funded report to establish an Aid Guarantee Facility for underpinning global aid<sup>6</sup>.

Throughout the paper, reference is made to row numbers in Table 1, which summarises the advantages and disadvantages of options for dealing with each of these issues.

## *What can be done? Issues and options*

### **2. Encouraging governments to reflect donor promises of increased aid in their expenditure plans**

#### **a. The problem**

Although donors have promised increased aid at the global level, this is not reflected in commitments to the expenditure programmes of individual countries. Aid commitments to countries are short-term, with indications of future aid levels rarely stretching beyond three years. This is clearly insufficient – the scaling up of expenditure that is required in low-income aid dependent countries will only be sustainable if the increased aid is maintained for many years, well beyond the planning horizon of most aid programmes<sup>7</sup>.

Even the medium-term indications provided by donors tend to be relatively conservative. Donors are usually reluctant to disclose future aid intentions before formally signing agreements, for fear of being criticised if subsequent budget cuts become necessary. A common pattern is for forecasts of donor aid to over-estimate disbursements in the coming year, due to implementation optimism, but to show a declining future aid pipeline by including only those activities that have been firmly identified<sup>8</sup>. This produces over optimistic assumptions for the coming budget, leading to a chronic problem of under achievement in budget implementation, but excessively pessimistic forecasts of the longer term outlook, leaving little or no scope for more ambitious plans.

Ministries of Finance in aid dependent Africa have recent experience of the problems caused by excessive budget deficits. Some are still struggling to establish macro-economic stability and budget discipline, and habits of prudent economic management remain fragile even in countries with a relatively long track record of improved macro-economic management. An important part of the struggle has been to move away from 'needs based' plans that were never implemented towards prioritised plans and budgets based on a realistic assessment of the resources available. The increased realism has brought significant benefits, and governments will not risk their improved economic performance on the basis of vague indications of increased aid that may not materialise and may not be sustained. In the absence of clear evidence of donor intent to increase and sustain aid flows, governments will continue to base their health and other expenditure

plans on resource assumptions that are far less than is required to meet the MDGs, and far less than is potentially available. Moreover, in the absence of more ambitious plans, any additional sums that are made available by donors are less likely to be well spent.

#### **b. Payment in advance**

One way to address the problem is by providing the funding in advance and irrevocably. Debt relief is the only form of irrevocable long-term funding that has been used on a large scale in developing countries (I.1), but (though welcome) it can not provide sufficient support to some of the countries of greatest concern. Other forms of payment in advance have been proposed, such as payment into some form of 'endowment' fund that would be invested in international capital markets and drawn on to finance future expenditures<sup>9</sup>. The endowment fund approach fails on a number of practical grounds, the most important of which is that Ministries of Finance in donor countries are unlikely to be attracted to payment in advance of need. Indeed, the proposed International Finance Facility takes the exact opposite approach of borrowing on international capital markets in order to defer the cost of expanding aid flows.

#### **c. Long-term commitments**

The obvious way to shift government assumptions about future aid levels into line with donor promises is for donor agencies to make long term commitments setting out their intended level of aid to each country (I.2). If the commitments are believed, countries can plan to meet long-term goals with confidence that funds will be available. It is unrealistic to aim for commitments covering the twenty years or more for which increased aid may need to be sustained<sup>10</sup>. A possible alternative would be to combine a five to ten year commitment with assurances that, at the end of that period, the donor will make every effort to limit the speed of reductions in aid to a gradual pace to which countries can adapt. A rolling approach could also be taken, regularly extending the forward commitment in order to maintain a pipeline of sufficient length to inform planning and budgeting.

Unfortunately, donors have not so far been able to provide meaningful long-term commitments. Legislative constraints or sensitivity about committing successor governments prevent some donors from making such commitments. Although some

donors are sympathetic to the principle, they have been able to do no more than provide broad indications of their future long-term intentions, and actual disbursements have proved vulnerable to being interrupted due to policy concerns that lie beyond the formal conditionality of the agreement<sup>11</sup>. Donors may also be reluctant to provide an increasing share of their aid in the form of long term commitments for fear of reducing their ability to respond to changing priorities or the threat of budget cuts. Donors are of course far better placed to manage such pressures than the poor countries they are assisting, but may nevertheless resist accepting the increased risk.

#### **d. Long-term commitments to specific expenditure programmes**

It may be a little easier for donors to make longer term commitments to specific expenditure programmes within a country (1.3). Donors have traditionally been able to make long-term commitments to projects, commitments that are usually honoured subject to any implementation delays. Projects are not a suitable instrument for funding a major scaling-up of expenditure dominated by recurrent costs, but it would be feasible to make longer term commitments of budget support earmarked to health. They could be designed to overcome the 'Catch 22' problem that aid to health may be low because plans are un-ambitious, while plans are un-ambitious because aid offers are low. Government and donor partners to the sector could work together in an iterative process to develop the sector plan and budget and identify the necessary funding.

The aim of earmarked long-term funding is to help finance more ambitious spending on programmes that both government and development partners regard as of high priority, but which the recipient government is unable to expand without additional and assured finance. However, it is difficult to know whether the aid, or the expenditure that it finances, is actually additional. Donors may fear that additional aid may be offset by a reduced government contribution, resulting in no overall increase in health expenditure but releasing government funds for other purposes. The government may fear that the aid allocated to health may not be additional but comes at the cost of lower donor spending on other sectors, distorting national priorities if no offsetting action is taken. Neither recipient governments nor development partners can be confident of achieving their expenditure intentions

unless there is an understanding on the expenditure programme as a whole, and how it will be financed.

Crosscutting reforms could also merit assured long-term funding. Salary supplementation would be one obvious example, to enable higher salaries to be paid now in order to recruit, motivate and retain key staff, with the supplements phasing out over time as GDP and revenue growth enables them to be met from domestic revenue. Reallocation of even a portion of the sums currently spent on expatriate advisers could have a substantial impact if re-applied to finance domestic salaries, but would need to be used for assured funding rather than being subject to hand-to-mouth conditions. The scheme could be either a general one, or limited to specific categories of staff that are difficult to retain, or used to attract and retain staff to live and work in rural areas where the poor live.

There is a danger that long term donor spending commitments earmarked to specific spending programmes may result in a transfer of perceived ownership and responsibility, as a government gets used to not budgeting its own funds for the purpose. This concern can be partly addressed if donor funding is part of the government budget, using government systems to plan and disburse funds, perhaps with donor disbursements triggered by reimbursement requests.

#### **e. Collective donor assurances of future aid**

Although longer term commitments are a highly desirable and indeed essential part of the solution, they do not provide more than a very partial answer. Donors are unlikely to be able to make the longer term commitments that are required. If they do provide longer-term indications of support, they will be hedged around with caveats and are unlikely to be believed without heavy discounting of promises. Indeed, prudent finance ministries would be well advised to discount donor promises in the light of experience.

One approach to addressing the problem of individual donors failing to disburse at expected levels could be a collective donor commitment to maintain aid above a specified level, with shortfalls by one donor made up with additional commitments from others (1.4). The level of donor support to be defended in each country could be based on government assumptions included in the budget and the medium-term expenditure framework. There have also been a number of attempts to provide similar assurances through international agreements.



The Strategic Partnership for Africa (SPA) in the 1990s, for example, attempted to ensure that no African country with a credible adjustment programme would fail for lack of donor finance, while the Fast Track Initiative is motivated by a similar objective with respect to the funding of programmes to achieve Education for All. Unfortunately, it is difficult in practice to make collective assurances work, either at the country or the global level. Donors try to avoid having idle funds, and the commitment and disbursement lag is such that it is difficult for replacement funding to be disbursed in the amounts required at the time when it is needed. Attracting additional commitments will be especially difficult if the cause of under-disbursement is related to policy reservations by a specific donor. Other donors may not share the specific donor's view of the situation and the case for reducing aid, but may nevertheless be reluctant to increase their own exposure. Given these various problems, a dedicated facility, as proposed in a DFID financed paper discussed in section 5, would seem to be a necessary underpinning to make any collective assurance credible.

#### **f. Increase donor credibility by making aid less dependent on annual donor budgets**

The credibility of the promised increase in global aid will be increased if measures are taken to make future global aid flows less dependent on annual budget votes (1.5). Measures such as the IFF (and the 'mini IFF' recently established to support GAVI), the proposed tax on aviation fuel or airfares, global carbon taxes, or the use of gold sales or SDR issues to fund development finance have the merit that, once agreed, they provide a secure stream of additional global development finance<sup>12</sup>.

The funding of the multilateral development banks is agreed over longer-term periods and can be supplemented from their profits and capital market borrowing, making them less subject to fluctuations than the bilateral agencies. One way to secure the promised aid increases would be through larger and longer-term capital replenishments for the multilaterals. If funding for the multilaterals were to be linked to hypothecation of some global tax, such as airline taxes, there would be a guaranteed source of future vigorous growth in resources for aid.

It is recognised that considerable time and effort will be required to make progress towards implementing any of the proposals at 1.5.

#### **g. Improve aid forecasting, based on better donor reporting and accountability**

Although Governments should continue to be sceptical of donor promises, it does seem clear that aid is increasing, and that developing countries should factor the increase into their plans.

Donors should help Governments to make realistic assumptions about the level of future aid they should assume. The main focus should be at country level (discussed under aid volatility), but there is also a useful role for improved international aid reporting and forecasting. In the same way that the World Bank produces commodity price forecasts that are helpful to country economic managers in making assumptions about export earnings and tax revenues, it would be possible to produce global and regional aid forecasts to help countries make reasoned assumptions about the aid they might receive, based on an informed assessment of the overall aid environment (1.6). It is suggested that this role might be taken on either by the DAC or by the World Bank. The DAC has published on its website a donor by donor forecast of aid to 2010, but it is explicitly based on the assumption that OECD donors deliver on their public statements. The World Bank produces a limited forecast for Global Development Finance and might be the more obvious choice, given that the consensual nature of the OECD may make it difficult for it to be associated with forecasts that would need to take a realistic and sometimes sceptical view of donor assertions.

The value of such aid forecasts would be to provide a starting point for framing realistic aid assumptions to be used in PRSPs, IMF programme discussions, medium term expenditure frameworks, sector programmes, and public expenditure reviews. The global aid forecast would provide a reality check on national assumptions. For example, it might prompt questions if the country is assuming aid to be flat when the global and regional forecast is for a significant increase. The reasons for the difference would need to be investigated, comparing aid: GDP ratios to the regional norm for countries of similar per capita income and population, and considering whether there are factors affecting aid effectiveness that might account for the difference. In other words, by informing judgements about the future aid environment, use of the forecast would help to avoid systematic bias in aid assumptions.

The value of aid forecasts depends on their quality. It would be difficult to produce meaningful forecasts without some related improvements in



donor reporting. It is suggested that aid forecasting could be improved by each donor agency producing global forecasts of their overall future aid commitment and disbursement intentions, even if they are unable to make explicit future commitments to individual countries. These would need to include a reasonable degree of detail to be helpful. There is a particular need to improve reporting on the share of donor aid that finances Government expenditure plans. A significant share of the ODA flows that are reported to DAC never enter public expenditure or the budget, and do not contribute to financing the PRSP or Government plans.

A useful reality check could be provided if the annual DAC report included data on actual disbursements compared to previously declared intentions. This will require considerable effort to make donor reporting to DAC rather more meaningful than it is at present. Donor self reporting at present is impossible to compare with country level data on what has been received, and it is difficult to know what value or meaning to attach to it. Data that enabled donor promises to be verified would be immensely useful. It would provide an objective basis for adjusting aid forecasts. It would also enable Governments, civil society aid lobbyists, and donor peers to hold agencies to account, questioning the reasons for low disbursement and pressing for promises to be met. For that very reason, donors might be reluctant to provide indications of their future aid, and might also resist publication of the data. However, if there is reluctance to publish future aid expectations, that in itself is an indication that Governments need to err on the side of caution in discounting aid promises.

#### **h. Multiple aid scenarios for national planning**

Even with these measures in place, Governments will face uncertainty as to their future aid flows. There may therefore be a case for low-income countries producing more than one forward scenario for their PRSP and medium and long-term expenditure plans, reflecting inter alia the impact of alternative aid assumptions (1.7). The preparation of multiple scenarios does imply additional effort by hard pressed Governments, and there are dangers of demotivating staff if the higher scenario proves impossible to implement due to lack of resources. Nevertheless, a clearly articulated ‘high’ scenario, setting out what could be achieved with higher aid, would be valuable for persuading donors to increase their commitments, and would also help

ensure that unexpectedly high commitments can be used in a timely and effective manner.

#### **i. Procurement subsidies**

In addition to measures to increase long-term aid, there has also been discussion of measures to address the problem from the other side, reducing the cost of procurement of medicines and other supplies by global subsidies and advance bulk purchase. This can have a significant and very positive impact by reducing the scale of the funding shortfall that needs to be bridged.

### **3. Reconciling longer-term commitments with aid effectiveness**

#### **a. The problem**

Since the early 1980s, donors have used conditionality to ensure that aid is disbursed in a policy environment in which it can be effective (2.1). Budget support is particularly dependent on reaching an understanding with Government on future policy measures, but the approach is also common in sector discussions, and the ‘policy matrix’ is also a common feature of PRSPs that have a significant influence on the overall level of donor support. The donor approach has been modified to place less emphasis on buying future promises, and more on Government ownership and the track record of implementation. However, the modifications of approach that have been implemented or are under discussion do not address the fundamental problem that Governments are being asked to take on long-term spending obligations based on short-term and conditional offers of support. The Government must be confident not only that it can implement current agreements with donors, but that it will be able to keep the aid flowing by negotiating a series of future agreements, the terms of which are presently unknown. Most forms of programme aid or budget support are based on an annual commitment cycle, linked in best practice cases to the Government budget cycle. Although this can bring greater predictability to the annual budget, it is of little help to a Government deciding whether it dare take the risk of relying on aid to implement a long-term plan to scale up public expenditure, involving recurrent expenditure obligations that will be difficult to withdraw from if funds fall short.

The risks are multiplied by donor insistence on retaining clauses that enable them to withdraw aid if Government behaves in ways that they find un-

acceptable. It is clearly necessary to be able to withdraw funds in the light of major corruption scandals or human rights abuses. The problem from the Government perspective is that it is difficult to predict or control the issues over which donors may choose to interrupt funding, and the potential intrusion on national sovereignty can be difficult to accept.

#### **b. 'Entitlement' approach**

The only way to provide completely assured long-term funding would be through an 'entitlement' approach to aid allocation (2.2), with commitments based on need and maintained irrespective of Government behaviour (though aid could perhaps be directed through non-Government routes in the worst cases.) This would ignore the evidence that aid achieves less in difficult environments, and would be unlikely to be acceptable to donor Governments, nor would it result in the best contribution to poverty reduction.

#### **c. An allocation model with performance assessment**

A more realistic approach to the need to ensure aid effectiveness in the context of moving towards longer-term commitments would adjust the level of commitment each year based on an annual assessment of need, and of the policy, institutions, and progress being achieved towards development outcomes (2.3). The level of aid would change slowly in the light of changing performance, giving enough time for dialogue on how matters can be improved and, if unsuccessful, giving Government time to adjust spending commitments to a more constrained aid outlook. Ideally, the aid allocation model(s) in use should include not only policy and institutional indicators, but also (and perhaps mainly) indicators tracking the change in outcomes, as Ravi Kanbur has argued<sup>13</sup>. This would shift the policy debate towards what is working rather than what is popular with the donors, and would be consistent with improved country ownership and responsibility.

Ideally, the approach should apply to total aid to a country, from all sources. This could be done through a joint consultation and commitment process. The Commission for Africa proposed something broadly along these lines:

*'To improve the quality of aid an annual discussion should take place between the*

*Development Ministers of the OECD countries and African Finance Ministers, along with representatives of civil society and international organisations. This should consider aid allocation criteria and make suggestions for a better distribution, including between middle and low income countries. In countries where governance and institutions are weaker, donors should seek to provide adequate and effective flows through appropriate channels, bearing in mind the need to avoid undermining national systems and/or long-term sustainability<sup>14</sup>.'*

Either as an alternative or a complement to such an approach, one or more donors (the World Bank?) could operate as 'swing donor', taking explicit account of other donor commitments when allocating funding in order to achieve a desirable global allocation of aid. This might have the added benefit that donors with a poor track record would be forced to reform, since partner Governments would be more inclined to refuse poor quality aid in the knowledge that lower receipts from weak donors would be at least partly compensated by higher receipts of better quality aid from the World Bank. The swing donor role might be controversial, given that it explicitly seeks to alter the impact of allocation decisions by bilateral donors.

The main constraint on moving towards such an approach to conditionality is probably the continuing donor need to react quickly to serious problems of a political, governance, or human rights nature. It is unlikely to be feasible to insulate aid flows from such concerns, though it might be possible to ensure that funding that is clearly linked to specific long-term welfare goals is protected even if aggregate aid to Government is reduced.

#### **d. Conditionality at sector and sub-sector level**

There are a number of alternative approaches in use that attempt to provide reasonably predictable, on-budget funding to medium-term expenditure programmes, whether sectoral SWAPs or vertical interventions in areas such as HIV-AIDS. The main donor concern about making longer commitments

to sectors is how best to ensure that they are well used, given that ‘blueprint’ style conditions and complete definition of future spending programmes is not feasible beyond a short to medium term time frame (2.4). Longer-term commitments therefore require a combination of both conditions at entry, and agreement on how future decisions will be made in order to ensure that the agreed goals continue to be pursued effectively.

These considerations could lead in the same direction as the ‘aid allocation model’ option, with long term indications of support if progress is maintained, annual performance review, and specific assurances that worse than expected performance will provoke first discussion, and then a moderated response calculated to be gradual enough for the Government to adjust to lower aid flows (2.5). Such a partnership approach is close to existing practice in sector SWAPs, some of which have already been in place since the mid 1990s, and have weathered major disagreements.

#### **e. Expenditure programmes meriting long-term finance with minimal conditions**

It might be feasible for donors to provide assured long-term finance for specific expenditure obligations judged to carry a low risk of significant policy disagreements, irrespective of problems in other aspects of the aid relationship. Although the effectiveness of most public expenditure depends on the overall effectiveness of public sector management, it may be feasible to identify some expenditure areas where long-term commitments are particularly needed and where donors are willing to make them with minimal and clearly specified conditionality. Treatment of HIV/AIDS patients is the most obvious (and most expensive) one. Once people are started on HAART treatment, it would be unethical not to continue it, yet treatment programmes are being committed in five-year tranches, even though Governments will be unable to sustain them thereafter. It should be axiomatic that AIDS treatment programmes take responsibility for maintaining the treatment of those recruited to the programme for the rest of their life; indeed, where the programme creates an expectation that the much larger numbers yet to show symptoms should also receive treatment, it will be necessary to also meet those costs externally. If donors cannot provide such assurances, it could be argued to be irresponsible to encourage countries to embark on treatment programmes that divert funding from interventions that could save more lives at lower cost.

There is no reason in principle why longer term commitments to specific spending programmes should not be made in countries with relatively weak policy and institutional frameworks, particularly if the scale of the donor commitments enables programmes to be significantly protected from some of the problems. However, the stress on Government ownership might be different in such environments, with a focus on helping to build competent and accountable institutions, but with more checks and balances and more earmarking of funds until and unless such efforts pay off.

#### **f. Conditionality and predictability: Summary**

In summary, the approach to conditionality needs to change if longer-term commitments are to be a basis for longer-term and more ambitious plans to reach the MDGs. It seems unlikely that commitments can be entirely unconditional. However, there is scope for moderating the share of aid that is subject to interruption for non-performance, and moderating the speed at which donors react to poor performance, in order to build in time for dialogue and, if agreement is not reached, for adjustment to lower aid levels. Specific longer-term spending obligations could be supported by assured and longer-term commitments from donors, subject to Government implementing the agreed plan and spending allocations. Commitments will never be made for the 20 year period that increased aid will need to be sustained in some country cases, but sufficient assurance might be provided by a combination of 5+ year commitments, assurances of notice before funding is reduced, and a reasonable faith that good performance will continue to attract the required aid to sustain services. Assurances would be more effective in the context of coordination arrangements in which Government and donors jointly review funding needs and identify ways to meet any financing gap. As a DFID financed report has suggested, country level donor efforts to provide more secure donor finance could be underpinned by access to a new Aid Guarantee facility, an external source of funds to compensate for unanticipated funding shortfalls. Section 6 sets out the proposal in more detail.

### **4. Ensuring donor support helps finance the government plan**

With limited resources available, it is important that they be prioritised in support of a single strategy, plan, and budget that has been prioritised and

assessed for longer term sustainability. This does not imply some form of Stalinist central planning. The Government strategy may well include support for a mixed system with a combination of public and private finance and a range of service providers. It may include provision for supporting a range of pilot projects designed to learn lessons for future replication. It may involve a good deal of devolution of responsibility to local authorities. However, what it needs to avoid is a situation where uncoordinated donor interventions result in big differences between areas in the resources and services that are available and the ability of the population to access them. It needs to avoid expensive health interventions being prioritised over others that may save more lives for the same budget.

In terms of the macro economy, much depends on the foreign content of donor commitments. The Ministry of Finance and the Central Bank will have established with the IMF a macroeconomic programme that aims for a growth in domestic demand that is thought to be consistent with their inflation target. Unless aid is spent entirely on foreign exchange with no implications for domestic demand, any aid expenditure can in principle only be accommodated within the macroeconomic programme by displacing some other expenditure with equivalent impact on domestic demand. If donors fund activities that are outside the Government plan, Government has two alternatives. If it leaves total public expenditure unchanged, the donor support will displace other expenditure that Government would have preferred. If a reasonable plan has been produced, expenditure allocation is unlikely to be improved by sacrificing elements of it in favour of donor project commitments that have less Government ownership. If Government decides instead to increase public expenditure to include the off-plan donor commitments, it adds to aggregate demand, and may require a tighter squeeze on the private sector in order to accommodate the extra spending. Although these issues may seem of little practical significance at current levels of aid spending, they will become important if aid is significantly increased. It matters a great deal whether a 10% of GDP increase in aid is used to finance agreed national priorities, or ends up displacing private investment and higher priority Government spending programmes in favour of donor interventions of doubtful sustainability.

It is therefore proposed that donor funding needs to give first priority to filling gaps within the

Government strategy, plan, and budget for the sector. Donor agencies can and should participate in the dialogue around the formulation of Government policies and plans, but their support should focus on helping Government to fill the financing gaps in order to realise the strategy that has been articulated.

## 5. Reducing the cost of aid volatility

### a. The problem<sup>15</sup>

Aid is a far more volatile source of finance than domestic revenues. This volatility is most severe in those countries that depend most heavily on aid. The variability of aid does not offset the impact of other shocks on the receiving economy, but actually seems to amplify them, increasing in good times, but falling when difficult conditions increase the need for external finance. The problem of aid variability is highest in countries suffering high levels of domestic revenue variability, compounding their problems.

Aid is not only very variable, it is also hard to predict. Donor commitment promises are so unreliable that predictions based simply on past trends are more accurate than those that make use of donor commitments. Average shortfalls in aid receipts relative to the budget were equivalent to nearly 2% of GDP in a sample of 28 countries, with no less than 24 of them suffering shortfalls. Moreover, the shortfalls were greatest on programme aid, the untied funds of most importance for macro and budget management. Even countries that met policy conditions experienced large shortfalls<sup>16</sup>.

The uncertainty and unpredictability of aid has a statistically significant negative impact on growth. It also makes macro and budget management more difficult.

### b. Best practice approaches

A number of best practice approaches have been identified to tackle the problem of short-run aid volatility, particularly with respect to budget support<sup>17</sup>. Where budget support groups exist, donors are trying to move towards providing medium term indications of future aid, committing funds early enough to inform budget preparation, being explicit on donor conditionality (but with not all funding vulnerable to poor performance), providing budget support disbursements in a single tranche scheduled early in the year, with active reporting and monitoring of actual flows, and using Government procedures to disburse and account wherever possible.



As far as possible, conditionality is being applied to the following financial year, avoiding disruption of the approved budget. Similar approaches are beginning to be considered in sector wide approaches.

Where they are effective, these approaches facilitate timely and full budget implementation, and give Government more time to react and adjust to donor concerns and funding intentions. The problem is that the formal agreements have not prevented individual donors interrupting disbursements during the year due to political or human rights concerns not reflected in formal conditionality, while next year's budget remains hostage to the ability of the Finance Ministry to convince the donors that past performance and the future programme merit continued support.

In addition to measures to reduce the volatility of donor funding, it is also possible to mitigate the effects.

### **c. Use foreign exchange reserves to smooth fluctuations**

The impact of fluctuating aid levels can be smoothed through active use of foreign exchange reserves, and through adjusting Government use of domestic credit. IMF programmes usually include provision for automatic adjustments to foreign exchange and net Government borrowing targets to offset over or under estimation of donor funding. Foreign exchange reserve targets are normally set in relation to the need to smooth fluctuations in the foreign exchange market. It is arguable that it is at least equally relevant (in a world of floating exchange rates) to set foreign exchange reserves at the level required in order to smooth fluctuations in the resources available for funding the budget. It would be recognised that countries that are relatively more aid dependent (and those that are increasing their aid dependence) would need to also have higher foreign exchange reserves to cushion fluctuations in aid, and provide more time to adjust to any unexpected decline in aid levels. Rather than setting the foreign exchange reserve target mainly in terms of months of import cover, it could also be set with reference to fluctuations in budget resources and the required level of reserves to achieve a target degree of smoothing of the flows. The level would also depend on the size and sophistication of domestic credit markets, and the extent to which Government can finance any external aid shortfall domestically without incurring debt service problems or generating inflation or a squeeze on private credit.

Although it would be worthwhile to ask the IMF to look at the implications for forex targets of this approach, there are some important constraints. There are risks in encouraging Governments to think of foreign exchange reserves as part of budget finance rather than one of the resources available to an independent central bank for macro management; and there are clear temptations for Governments to raid larger foreign exchange reserves to help fund pet projects or their own re-election. Donors may also object to increasing aid to countries holding substantial foreign exchange reserves, though that problem should be possible to deal with through explicit discussion of the rationale for the target. The risks of Government raiding the reserves could also be reduced through the design of IMF programme targets.

It is possible that foreign exchange reserve increases may happen anyway as a consequence of a large increase in external aid used to finance an increase in public expenditure with a fairly low foreign exchange content. Central Banks have tended to accumulate foreign exchange reserves to avoid real exchange rate appreciation damaging export growth. In the short term, this problem may disappear due to the impact of higher oil prices, but it is likely to re-emerge, and the scope for ameliorating it through further import liberalisation may not be sufficient to absorb the level of aid increase that is now contemplated. If donors are able to adopt a relaxed attitude to the increase in foreign exchange reserves, this may provide a useful mechanism for building capacity for countries to protect themselves from future reductions in aid. The fiscal space implications, however, are not entirely benign. If increased aid is not absorbed through increased demand for foreign exchange, the implication is that the increased public expenditure has been financed from domestic rather than foreign sources, essentially by squeezing private sector demand.

### **d. Helping governments address absorptive capacity constraints — and ensuring donor procedures do not cause them**

Volatility or shortfalls in aid disbursements may not originate with the donor. Donors often ascribe low disbursement to absorptive capacity constraints within the recipient Government. Absorptive capacity constraints may reflect absolute supply limitations within the economy:- shortages of skilled personnel or of construction capacity that can only be overcome by bidding resources away from other



sectors in the short-term, or by investment in new capacity in the longer term. In most cases, however, the problems in making timely and effective use of additional external aid reflect problems in the effectiveness with which resources are allocated and managed. Common problems include late availability of budgeted funds, and excessively time-consuming and bureaucratic procedures for using them. Donors can help to address these issues by supporting public expenditure management reforms that aim to decentralise budgets and management authority to those responsible for delivering services, while themselves adopting 'best practice' approaches to ensure their own procedures are not causing delays.

Governments desire assured donor funding to avoid aid shortfalls leading to interrupted implementation or unplanned budget deficits. However, how should donors react when absorptive capacity constraints prevent Government from meeting their spending targets, resulting in a reduced need for funds? This issue is actually fairly straightforward to handle:-

- i. The main focus of collective donor assurance should be donor support to the annual budget. Dialogue between Government and the donor group providing budget support should be capable of identifying funding gaps relative to previous assumptions reflected in the budget and the MTEF. A methodology involving advance funding of an account that is replenished based on evidence of expenditure provides a 'cushion' of funds that gives time for aid shortfalls to be made up from new commitments, without causing interruptions in budget implementation. On the other hand, aid disbursements would not be triggered if low budget implementation meant there was no need to replenish the account. In principle, budget support could become the main mechanism for external support to Government expenditure, including the development or investment budget.
- ii. Where donor commitments continue to be given for specific Government projects or for earmarked support (e.g. condoms or other commodity imports), the key question is whether the costs of the programme are fully covered by Government and donor funding commitments. Government would as at present seek additional donor commitments for filling funding gaps (for example, to keep the future pipeline of drugs and other commodities full). However, if programmed expenditures are fully covered by existing com-

mitments, a shortfall in expenditure reduces aid disbursements, but the remaining balance of donor commitments remains available for when implementation picks up, and no funding gap is created. The low disbursement might trigger a review of the causes of low implementation and what can be done about them, but would not be an argument for seeking additional commitments.

- iii. Donor commitments to projects or programmes that are outside the Government budget would remain the responsibility of the donor, and would not be the subject of any collective assurance.

## 6. Insuring countries against donor non-performance?<sup>18</sup>

### a. The problem

The long term nature of the public expenditure obligations involved in trying to achieve the MDGs will inevitably make Governments wary of embarking on a major scaling up of expenditure based simply on faith in the continuing goodwill of the donor community. It may be helpful to establish a mechanism to insure aid-dependent countries against the risk of aid donors not fulfilling their promises.

### b. Proposed Aid Guarantee Facility

The Aid Guarantee Facility that has been proposed in a DFID-funded study would aim to limit the risk that aid may be less than has been promised, may be excessively volatile, and may decline abruptly leaving Governments with obligations that are difficult for them to meet. Access to the facility would mean that, even if donors provide no long-term commitments, Government can be confident that the speed at which aid declines from peak levels will be moderated to a pace that they should be able to adjust to.

### c. What types of aid should be stabilised?

Access to the facility would be limited to highly aid dependent low-income countries, to focus support on countries most vulnerable to aid shortfalls, and to limit the cost. For eligible countries, the facility would guarantee minimum levels of programme aid (general and sectoral budget support, plus some types of commodity support and basket funding). Project aid would be excluded because it covers a wide range of disbursement methods, is difficult to monitor, and because spending often reflects physical implementation and therefore aid shortfalls need not imply a funding gap that needs to be filled.

#### d. Suggested procedure for accessing funds

The proposal is that:

- Each eligible country, with the endorsement of the participating donor group, would agree with the facility managers which categories of aid will be insured against shortfalls, how disbursements will be monitored, and what level of expected aid will be guaranteed.
- In the third quarter of the budget year, the Government, together with a designated lead donor, would assess the expected disbursements of relevant categories of aid compared to the guaranteed minimum and, if there is a shortfall, apply to the facility for a drawing on the fund. To avoid the need for a cumbersome and time-consuming process for verifying and agreeing the numbers, the other donors providing finance would be copied in but only consulted on a 'no objection' basis.
- If there were no objection from donor partners, funds would be released on a non-discretionary basis by the facility managers, within (say) one month of receiving the application, enabling disbursement to occur within the financial year to which the application refers. The facility managers would only conduct basic checks to ascertain that the guaranteed funding level was as previously agreed, and that the donor partner had endorsed the estimates of likely disbursement.
- There will be discrepancies between actual aid disbursements and those expected at the time of application. Excess drawing from the fund would be repaid in the following year, subject to not causing a dip in aid below the guaranteed level for that year. If the initial drawing proves too low, supplementary requests should be made once it becomes clear that aid has been over-estimated.
- The facility would operate as a revolving fund, but drawings from the fund would only become repayable if and when actual aid receipts exceed the guaranteed level for the relevant year, and will be limited in amount to ensure that aid net of repayments never falls below the guaranteed level.
- Access to the facility would be unconditional, unless two or more donor partners object, in which case the proposal would go for final decision to an international panel with good representation from low-income countries. The aim of this procedure is to protect the facility from the risk of having to disburse in extreme circum-

stances such as societal breakdown or grave human rights abuses, while also protecting the Government from donors arbitrarily denying access to the facility. For reasons of speed and cost, the panel would use e-discussion, conference calls or video conferencing to make quick decisions, and would have a sufficient number of alternates to avoid delaying decisions for lack of a quorum.

#### e. Defining minimum guaranteed aid

The DFID study leaves open the definition of minimum aid levels to be guaranteed. To fully meet the objectives, guarantees would need to be of two types, both of which would be applied in all eligible countries.

The first guarantee protects countries from a sharp decline in the level of disbursements, and is independent of the level of commitments that donors may have made. For example, the facility might guarantee that disbursements of relevant categories of aid in any year, including drawings on the facility, would not fall below (for example) 90% of the average of the two previous years. This would ensure that, having used aid to increase public expenditure, the country is not then faced with a massive financing gap due to an abrupt withdrawal of budget support. Disbursements may still decline over time, but the facility would aim to limit the speed of decline and give the Government more time to adjust spending obligations to the reduced level of external support.

The second guarantee would apply in circumstances where donors have committed themselves to increase aid, and would insure the country against the risk of donors falling short of their promises. The normal profile in a scaling-up situation will be one in which the pipeline of future donor commitments implies increased aid for the next two to three years, tailing off thereafter because of relatively short donor commitment horizons. If longer-term commitments are made, it is possible that the country will request the fund to guarantee a relatively steep and relatively long-term increase in aid. The facility managers will assess the risk and inform the country of the aid levels that it will guarantee. The normal approach will be for the facility to guarantee a minimum rate of increase during the period when aid receipts are expected to grow. For example, if donor promises indicate a 20% per annum increase in the relevant categories of support in the next two budget years, the guar-

antee might aim to ensure that actual disbursements increase by at least 10% each year above the previous actual disbursements (including drawings on the facility).

The two guarantees, taken together, ensure that a reasonable proportion of promised donor increases in budget support will be received, and that (once a higher level of aid receipts has been achieved) disbursements will be phased out slowly rather than abruptly withdrawn. These two guarantees, taken together, significantly reduce the risks of relying on aid to finance higher public expenditure.

#### **f. Ensuring the solvency of the facility**

The guarantees offered by the proposed facility will only be credible if Governments are convinced that the facility will not itself run out of funds. Some arrangement is needed to underwrite the funding of the facility which, although set up as a revolving fund, will not be self-sufficient and will need a secure source of long-term funding. The problem could be solved by signed long-term agreements from supporting donors, or by linkage to one of the sources of long-term funding discussed in Table 1 (row 1.6).

The facility would also need to limit the risk of continuing to guarantee previous donor promises of medium to long-term increases in relevant categories of aid in a situation where circumstances have changed and disbursements are static or falling. There is a danger that perceived poor performance may lead donors to reduce their disbursements to a country, making the aid guarantee increasingly unrealistic if not revised, and posing a risk to the solvency of the facility.

To control this risk, it has been proposed that, after any drawing on the facility, the Government and contact donor should submit a joint letter setting out the causes of the shortfall, and what action has been taken to mobilise additional funds and improve disbursement outturn. If a country draws particularly heavily (aid less than 70% of guaranteed levels, or more than 15% of fund resources?) or persistently (either two or three years in a row), then Government and donors to the country would review the situation with the facility manager, to assess whether the guaranteed minimum aid levels remain appropriate and how they can continue to be funded.

The action taken following a review will depend to some extent on the nature and causes of the donor shortfall.

It is proposed that, in all but the most extreme circumstances, the facility should always prevent a sharp reduction in aid from levels experienced in previous years. The only circumstances in which this would not apply would be egregious corruption, major deterioration in human rights or security, or planned aid withdrawal following a big increase in wealth due to, for example, bringing on stream of significant oil or mineral production. The facility would thus ensure that the operation of conventional policy conditionality results in a slowing of aid disbursements rather than an abrupt cut.

It is more difficult for the facility to guarantee previous promises of continuously rising aid levels if actual disbursements are flat or declining. One way to provide a useful guarantee without risking exponential growth in drawings would be to base the guarantee on achieving a minimum annual increase above actual disbursements in the previous year or two, including facility drawings, but with the speed of increase limited by the exposure the fund can afford. The proposed review would then examine whether donors still intend to increase their support, and would adjust the guarantee as necessary to reflect a realistic future profile.

This approach, though inevitable, is a little unsatisfactory, in that it protects countries from abrupt declines in aid, but does not ensure that aid will grow as rapidly as has been promised. To mobilise aid for countries facing shortfalls, increase pressure on donors, and enable civil society organisations to monitor action and lobby for more to be done, the facility web site could publish data on countries making use of the facility, and copies of the explanatory letters and review findings, drawing attention to the scale of the aid shortfalls and actions needed.

#### **g. Next steps**

The quickest and simplest way to get something up and running would be to develop a proposal and then seek voluntary donations from interested donors. Detailed modelling is required to establish the required size of the facility, and review alternative options for country coverage and the level of guarantee. If the proposed facility is felt to have merit, a working group of interested donors and potentially eligible countries might be convened to develop it further, commissioning a more detailed design study to flesh out the organisational arrangements and operating procedures, and to estimate the financing required on various approaches to defining eligibility for funds. Outline TORs for a design study were included in the DFID study.

To reduce the risks of funds lying idle or of donors facing unexpected and large calls for supplementary resources, it is suggested that the proposed facility should focus to begin with on a small group of very poor and aid dependent countries, and with cautious assumptions as to the minimum aid guarantees, in order to ensure that costs are within the resources available. The ambition of the fund could be expanded as experience improves knowledge of the financial risks, and as (hopefully) success attracts additional donor contributions.

#### **h. Health Sector Guarantee Fund?**

The DFID report suggests that it would also be possible to develop one or more sectoral funds to guarantee aid for specific purposes, such as the expansion of health sector expenditure. The idea is not, however, fully developed.

The main issue that would need to be addressed in applying the idea at sector level would be how to define aid to the health sector, in a context in which an increasing share of ODA to some of the more aid-dependent countries is being provided as general budget support, not earmarked to specific sectors or purposes. There would be a number of issues to be addressed:

- It would not be appropriate to guarantee funding earmarked to health in a situation where total aid is in line with promised levels, but aid earmarked to health had been reduced in favour of general budget support, or spending on a different sector. In such a situation, Government is able to make up for any shortfall in health aid from the increased general budget resources now at its disposal.
- It would also be inappropriate for donor support to compensate for reduced Government

health spending from domestic resources, but this may prove difficult to identify in a situation where the amount of donor support helping to finance the overall budget and the health budget may be changing.

- If Government favours receiving an increased proportion of aid as general budget support, it is important to avoid designing a sectoral guarantee fund that provides a positive incentive for donors to continue earmarking their aid to health.
- There is no point compensating Government after the event for donor failure to provide finance for expenditure that did not take place.

Although it should be possible to design a sector guarantee fund that is capable of handling these problems, it would be complicated and not very transparent, and might as a consequence fail to achieve the main objective, which is to convince Government that it can safely increase health expenditure based on increased aid commitments. It is therefore suggested that any guarantee fund should be general, rather than sector specific.

#### **i. Response to comments on the DFID-financed study**

The initial DFID study has so far received only limited discussion. Annex 1 discusses the comments received to date. Although the practical and political difficulties that need to be resolved are formidable, there is nothing in the comments that need prevent the suggestion receiving further study. It remains the only proposal on the table that has the potential to provide aid-dependent Governments with the assurance they need that future aid will be reasonably close to promised levels, and that any subsequent reductions will be phased at a speed to which they can adjust.



## Annex 1 Proposed Aid Guarantee Fund: Comments on the Proposal and Responses from the Author

Comment	Response
<p>An Aid Guarantee Fund could do little or nothing in cases where the reason for the gap between commitment and actual expenditures is due to public expenditure management issues in the recipient country. Rather a program that helps the country overcome these flaws is needed.</p>	<p>It is of course true that implementation problems may result in lower than expected expenditure, reducing the need for aid or for minimum aid guarantees. The proposal aims to guarantee only budget support, recognising that the development budget (mainly funded by project aid at present) is likely to be prone to implementation problems with reduced expenditure matched by reduced finance.</p> <p>Of course, budget support may also be funding areas of expenditure that can be subject to implementation problems, especially if expenditure is increasing rapidly. However, the likelihood of experiencing implementation problems can be reduced if aid is reliably available when needed. Access to guaranteed minimum budget support will be a helpful complement to programmes to improve public expenditure management, enabling the Ministry of Finance to make the full and timely budget releases that are necessary to underpin planned improvements in budget formulation and execution.</p> <p>Aid shortfalls cause major damage to economic growth and public expenditure outcomes, whereas much good, and little harm, is done by donors meeting their budget support commitments in full, even if public expenditure is lower than budgeted. Government borrowing will be a little lower, foreign exchange reserves a little higher, while annual expenditure and PRSP reviews can address the causes and remedies and the implications for the budget in the following year. In any case, the proposal is to guarantee only a portion of expected budget support, keeping any shortfall within manageable bounds, but not eliminating it.</p>
<p>The facility is essentially an insurance mechanism. As such, the incentives created by the facility for both donors and recipients must be carefully taken into consideration to avoid moral hazard. This is especially true for the case of insurance against non-disbursement due to non-compliance with conditionalities. If the condition in question is fully under the control of the recipient country, there should be no need for such an insurance mechanism. The facility should not be used for "fixing" conditionalities which were poorly designed or should not have been set in the first place.</p>	<p>The problem is that the aid will be needed long-term, but the conditions are set annually, so that the Government is taking on the risk of increased aid dependence without even knowing what conditions will be imposed in return for funds that have yet to be committed. Conditions are therefore not in any sense 'under their control.' With the proposed facility in place, Governments that are unable to agree to donor conditions or do not comply with them will face a reduction in their future aid flows, but it will be at a measured pace, designed to give them time to adjust their spending obligations to lower than expected aid receipts. The guarantee limits the impact of short-term conditionality, recognising that Governments need to implement reforms because they believe in them, not because of donor conditions, and that dialogue and slow adjustment to funding levels is likely to produce better development outcomes than stop-go did.</p>
<p>The Facility must be carefully designed to avoid moral hazard on the part of both donors and recipient countries.</p>	<p>In addition to policy conditionality, discussed above, the design recognises dangers of creating incentives to distort aid figures in order to maximise drawings on the fund, and seeks to reduce them through dual Government and lead donor responsibility, and through the requirement for reviews of fund drawings. Donor exaggeration of commitments will attract publicity and pressure from peers and CSOs.</p>



Comment	Response
<p>In the case that the facility is geared towards insuring volatility caused by donor behaviour, it would make sense that the repayments for drawing on the facility be made by the donors and not by the recipient countries.</p>	<p>Who pays makes little practical difference. Repayments will only be triggered if aid receipts exceed the guaranteed level. Although obliging the donors responsible for the shortfall to repay may appear attractive, attribution and collection is likely to prove a messy political and bureaucratic process. The proposed approach has the merit of simplicity. In the event that obtaining repayment proves difficult, the option of budget support donors making repayments to the facility as a first charge on new support is potentially available.</p>
<p>The Aid Guarantee facility cannot and should not insure against all... causes of volatility.</p> <p>The instrument is probably most appropriate for insuring against those risks caused by donor behaviour or that are exogenous in nature.</p> <p>There is an urgent need for a detailed analysis of the relative importance of the factors causing volatility of aid (defined as the difference between donor commitments for a given period and actual expenditures by the recipient country in such period). This volatility may be caused by multiple set of factors, some of which are the donors' responsibility (such as decreased commitments due to political and budgetary reasons or slow disbursement due to bureaucracy in the donor country), some of which are the recipient countries' responsibility (lack of capacity to disburse, public expenditure management difficulties or non-compliance with conditionalities under the control of the recipient country)</p>	<p>The proposal is to guarantee levels of budget support against all causes of shortfall from previously promised levels, with the exception of extreme circumstances (e.g. major corruption scandals, human rights abuses, governance breakdown), when the guarantee would be suspended only if either all donors agree or the suspension is approved by an independent panel. For reasons discussed above, problems of conditionality and difficulties of budget execution are not sufficient reasons for suspending the guarantee, which is in any case proposed to be partial, and would permit gradual reduction in aid levels over time.</p> <p>The proposed facility insures against shocks emanating from fluctuations in donor aid. It would not try to offset exogenous shocks via the terms of trade or natural disasters, though exchange rate impact on the value of aid does need to be insured against. The report proposes guaranteeing aid in terms of constant price units of the currency of the recipient.</p> <p>A study of causes of aid volatility may be valuable for other reasons, but is not required for the design of the proposed facility.</p>
<p>The Facility as initially proposed does not lengthen the maturity of the funding provided by donors, which, in the case of the social sectors, is a major deterrent to increasing recurrent expenditures in a sustainable manner.</p>	<p>The operation of the facility has the effect of increasing the maturity of donor funding, because it not only guarantees that promised increases take place, it also limits the subsequent rate of decline in future aid from the new peak. The extent to which this secures a guaranteed increase in funding into the medium-long term will depend on the funds available for the facility, and the implications for the percentage of promised aid levels that can be guaranteed.</p>
<p>A specific mechanism for diminishing the difference between commitments and actual expenditures, although reasonable and desirable in principle, requires further analysis.</p>	<p>Agreed. The report proposes discussion in a working group, and sets out terms of reference for a design study to take this forward.</p>

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# GLOBAL HEALTH PARTNERSHIPS: ASSESSING COUNTRY CONSEQUENCES

By Kathy Cahill, David Fleming, Michael Conway and Srishti Gupta, Paris, November 2005



## I. Introduction

In the last decade, over 70 health alliances, or Global Health Partnerships (GHPs) have been created to address today's complex global health issues. GHPs are now the dominant model of organization in this space. In 2002, the Bill & Melinda Gates Foundation and McKinsey conducted an assessment of GHPs, and identified five benefits.

When compared with individual partners, health alliances:

- Avoid duplication of investments and activities,
- Produce economies of scale,
- Pool resources to enable higher-risk activities than any partner would undertake alone,
- Share knowledge and resources to improve effectiveness, and
- Create momentum and attract funding by building a common "brand" that gains legitimacy and support.

We believe these benefits should enable GHPs to tackle major public health challenges such as HIV / AIDS, malaria, tuberculosis and vaccine-preventable diseases more effectively than individual players.

Indeed, our research suggests that these alliances have made progress in preventing and fighting diseases. They have won attention and financing for public health challenges at the highest political levels. Countries have boosted access to antiretroviral therapy for HIV / AIDS patients, raised vaccination rates and increased the use of directly observed therapy, or DOTS, for tuberculosis. The Working Group on Global Health Partnerships established by the High-Level Forum on the Health Millennium Development Goals also found that GHPs attract new partners into the global fight against specific diseases and spur innovation.

We know that GHPs work. The discussion, therefore, needs to shift from "Do we need such partnerships and what value do they add?" to "What will it take to increase their effectiveness and reap their full benefits?"

To answer these questions, the Bill & Melinda Gates Foundation and McKinsey & Company have conducted an assessment of country-level perspectives on GHPs. This study focuses on the issues that recipient countries struggle with when working with GHPs individually and collectively, in the context of the benefits GHPs deliver.

Specifically:

- What are the transaction costs and other consequences for recipient countries as a result of interactions with multiple GHPs?
- How can GHPs and countries address these consequences?

### About the research

We conducted field research for this study during the summer of 2005 in 20 countries<sup>1</sup>. We chose these countries because:

- At least two major GHPs are active in each of them,
- Both the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria have made grants to these countries, and
- They reflect a variety of geographies, development/ health spending levels, and population sizes.

Our team of eight people gathered evidence primarily through in-person and phone interviews. We used a structured, but not quantitative, interview guide. Examples of questions we asked are:

- How do GHP plans relate to national and district level plans and priorities?
- What should GHPs do to improve coordination and/or reduce the burden of current coordinating mechanisms?
- Has national monitoring and evaluation capacity changed as a result of GHP activity, and how has that been demonstrated?

We interviewed over 350 stakeholders from ministries of health, finance, and planning, multilateral agencies, bilateral development agencies, NGOs, district health management teams and local health facilities. We sought out people whose work lets them see the costs and benefits of GHPs directly. This includes people responsible for making policies, applying for grants, designing budgets and financial stability plans, attracting health care workers and strengthening health systems.

We sought the perspectives of the public, private, and civil society sectors. The findings are primarily in the public sector; however, since most GHPs choose to interact with governments. Where possible, we have tried to verify our perceptions with facts and/or cross-check these views with multiple stakeholders. We supported survey findings with data analysis and a review of secondary literature, including assessments of GHPs conducted over the last two years.

Our assessment focused on the major GHPs and global initiatives. These include:

- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- The Global Alliance for Vaccines and Immunization (GAVI)
- The Stop TB Partnership
- Roll Back Malaria
- The Global Alliance for Improved Nutrition (GAIN)
- The World Bank's Multi-Country HIV-AIDS Program (MAP)
- The President's Emergency Plan for AIDS Relief (PEPFAR)

Interviewees were most familiar with high-profile, grant-making GHPs such as the Global Fund and GAVI, but while most of the issues in this paper arise in the context of large GHPs, they are not unique to large GHPs. GHPs that are smaller and/or do not provide funding can also create distortions and extract similar costs. Therefore, the cost drivers and opportunities we identify apply across the spectrum of GHPs.

This report will look at what GHPs do right, issues that arise in their relationships with countries, and what GHPs can do better.

It is structured in three parts:

- Overview of GHP benefits
- Consequences stemming from GHP interactions
- Innovative practices and emerging opportunities to address these issues

## 2. Overview of GHP benefits

In addition to the two major benefits of bringing much-needed attention and funding to critical diseases, GHPs have helped countries in three key ways.

### a. GHPs have spurred countries to craft smarter policies and plan for the future

The GHP grant application process encourages countries to improve their capacity to plan and anticipate future needs. GHP feedback has also

helped countries craft plans for key diseases that might otherwise have been neglected.

Angola, for example, recently emerged from nearly three decades of civil war. The government historically allocated less than 5 percent of its budget to health. GHP funding has allowed Angola to look beyond these basic efforts. This has been especially crucial as the country transitions to peace. The civil war kept HIV/AIDS prevalence rates low (less than 5 percent reported incidence) because populations were often isolated. Development partners recognized that in the post-war environment, HIV/AIDS could spread as Angolans began to move freely. Donor and GHP funding from the Global Fund and the World Bank has been critical in controlling this epidemic before it starts.

In some countries, a combination of funding and procurement capability has increased vaccination rates. Vietnam, for example, had a limited hepatitis B vaccination program before GAVI offered its support. The country now vaccinates newborns for hepatitis B within 24 hours of delivery.

### b. GHPs have encouraged countries to improve transparency by strengthening program monitoring

In Zambia, for example, clinics monitor vaccination rates to report back to GAVI and other donors. This data is then used by districts when designing vaccination programs and targeting outreach (e.g. child health weeks and booster campaigns).

### c. GHPs have boosted stakeholder participation

Because GHPs interact with all players in the health sector, they have helped increase the profile of non-governmental stakeholders and the private sector. In Zambia, and Bangladesh (where over 50 percent of health care services are delivered outside of public institutions), NGOs have applied for and been accepted as principal recipients for several of the Global Fund's grants.

## 3. Consequences stemming from GHP interactions

These benefits, though, are not without their drawbacks. As the development community has known for years, introducing vertically-oriented external resources into horizontally organized health systems in resource-constrained environments is never easy. Given the expansion of GHPs during the last few years, we started this study fully expecting to encounter a range of issues arising from GHP interactions with countries.

Our study identified two major consequences for countries, and one compounding factor due to GHP interactions:

- i. Countries continue to struggle to use the new resources, given inadequate country systems and infrastructure. Though funding from GHPs has increased, GHPs do not provide adequate support, technical and other, to countries to meet the challenge of absorbing funds and implementing programs.
- ii. Because external resources, by default, arrive with their own processes attached, integrating GHP processes with those of recipient countries can be difficult. Unfortunately, countries are burdened with parallel and duplicative processes from multiple GHPs, because GHPs often bypass the processes that countries already have in place.
- iii. To complicate matters, GHPs have not communicated adequately or effectively with countries and partners. Communication between GHPs and countries is often one-way and the feedback loop from countries is weak. Furthermore, because GHPs are relatively new aid vehicles, relationships between GHPs and their partners at the global and country level have not been solidified. Indeed, this weakness amplifies all other problems.

In this section, we describe GHPs' deficiencies in each of these three areas.

#### **a. Countries struggle to absorb GHP resources**

Our research found that country stakeholders believe that GHPs do not adequately support shifts in policy and technology, do not provide adequate implementation assistance, and have created too many country coordination forums for such forums to be effective.

##### *i. GHPs do not adequately support shifts in policy and technology*

GHPs often explicitly or implicitly tie technology and policy recommendations to their grants. For example:

- GAVI has pushed countries to use the pentavalent hepatitis B vaccine.
- PEPFAR requires countries to use FDA-approved antiretroviral medicines.
- The Global Fund puts its weight behind the WHO policy on Artemisinin Combination Therapy (ACT) use for malaria.
- The Stop TB Partnership/Global Drug Facility favors the four-drug fixed-dose combinations for TB treatment.

These recommendations are based on what these GHPs and international agencies like the WHO believe are the most effective approaches. However, such tying has had some negative consequences and countries report concerns with the way GHPs make policy and technology decisions.

Tying funding to policy/technology shifts has created uncertainty and a sense, as one interviewee told us, of "being forced without discussion." In some cases, when a policy has shifted toward a newer technology or treatment guideline, key stakeholders have received mixed signals about the decision. Often, they don't receive evidence, such as cost-benefit analyses, to support the change. Neither the policy rationale, nor whether there is room for flexibility is communicated. Some GHPs do not adequately discuss the trade-offs and logistics of using new technologies. Finally, in some cases, country officials and local NGOs report that GHP-chosen policy/technology solutions were not the most appropriate for their countries given financial and health system constraints.

Consequently, stakeholders are insufficiently bought-in, rendering the process of adopting recommended technologies more difficult than necessary.

#### **Case study: The need for quicker responses to policy shifts in Burkina Faso and Angola**

African countries have long battled malaria, struggling with both costs and resistance. In 2002, domestic research in Burkina Faso demonstrated chloroquine, a relatively inexpensive therapy, was more than 90 percent effective in treating malaria, and had a 10 to 15 percent rate of resistance. The national health policy therefore supported using chloroquine for malaria treatment. The government applied to the Global Fund for a Round 2 malaria grant for the use of chloroquine, amodiaquine, and sulphadoxine-pyrimethamine to fight this disease.

After the grant application was approved, though, the WHO and the Global Fund made policy changes favoring ACTs. That, coupled with new reports showing that the rate of chloroquine resistance was under 15 percent in several districts, led Burkina Faso to develop a national policy of ACT use, even though ACT treatment is roughly 20 times more expensive than chloroquine. The country applied for full transition funding in Round 5, but in the meantime, Burkina Faso did not receive additional funds to cover the increased costs.

Country interviews during the summer of 2005 revealed that stakeholders remain concerned about these costs. They worry that the country succumbed to pressure to adopt the new technology in the absence of meaningful long term planning, and they worry whether the program will be financially sustainable.

Stakeholders in other countries expressed similar sentiments. In Angola, ministry officials found the Global Fund to

be slow to change the country's malaria grant from amodiaquine to ACT after new surveillance data showed higher levels of resistance to non-ACT therapies. Although the country eventually submitted a grant application for additional funding to cover the higher cost of ACTs, officials were frustrated that the change in treatment had to be implemented without clear financial sustainability planning or support.

## *ii. GHPs do not provide adequate implementation assistance*

Countries invest heavily in writing applications for GHP funding. They often hire external consultants, but these experts do not always understand what is feasible, and tend to leave before implementation begins. As a result, plans can be difficult to execute because no one has planned for what to do after the check arrives.

Across countries, we found ample technical assistance available for applications. Recent secondary literature supports these findings<sup>2</sup>. In 2003, UNAIDS provided technical assistance to all countries that wanted help writing Global Fund grant applications. Forty-seven countries asked for assistance and 27 (57 percent) were successful in obtaining grants – a success rate more than four times that of proposals developed without UNAIDS technical assistance.

But what happens after a country receives a grant? Country ministers repeatedly told us that GHPs did not provide them with adequate support for implementation. For example, for the Round 4 Global Fund HIV/AIDS application in Angola, UNAIDS invited three foreign consultants to write the application. These consultants have since left the country, but work plans have been inconsistent and no one can clarify assumptions used in budgeting and program design. The principal recipient for Angola, the United Nations Development Programme (UNDP), is midway through the process of rewriting work plans for the grant that was approved as part of Round 4.

Countries may also not understand what kind of funds they will need for implementing programs, or what programs they can realistically implement. GHPs note that targets are often overly ambitious, timelines unrealistic, and capacity inadequate. In Tanzania, bilateral donors reported that the country had issues with the scale of the Round 4 application for HIV/AIDS funding from the Global Fund – originally proposed at \$1 billion. At the time of application, in-country partners asked the government to scale back because “they did not think the Global Fund had that kind of money and that the country could not absorb that much money.” The

country scaled back the proposal by cutting back on the amount of money requested instead of spreading it out over a longer period to adjust for the time needed to ramp up new programs. As a result, after one year, the program has reached 10,000 people on treatment as a result of Round 4 money but now Tanzania is looking for additional financial support to scale up the program.

Inadequate support for implementation is a real threat to countries' ability to meet performance metrics. Laos, for example, a country with weak infrastructure and scarce talent, risked not meeting disbursement targets for its Global Fund grant and having its Global Fund funding held back until financial and monitoring and evaluation system issues were resolved. This would have created a negative cycle for the country.

To best serve countries, GHPs need to provide more and better technical assistance for implementation. Interviewees said they needed assistance in the following areas:

- Planning, budgeting and achieving financial sustainability – including financial planning, financial management, training in broad-based health planning and linking epidemiological data to medium- or long-term planning;
- Monitoring, evaluation and reporting – including strengthening existing systems, general monitoring and evaluation procedures, financial reporting, health management information system (HMIS) development, and commensurate funds to implement and support these activities;
- Expertise and human resources – including training in managerial skills, health planning and clinical skills; and
- Execution and implementation – including aspects of program design, procurement, logistics and access to best practices from other countries.

GHPs do offer some technical assistance, but our research found several problems with current provisions:

- First, countries report that the technical assistance they do receive is inadequate. This hinders their ability to use GHP funds effectively.
- Second, country partners report that ministry officials are often unable or reluctant to ask for specific technical assistance to implement the program that goes beyond basic needs. For example, in Zambia we observed that everyone from the central level down to the district level



knew there was a need for assistance, but this need was discussed vaguely as “capacity building” rather than becoming an actual request for help. In both Indonesia and China, partners noted that government officials were reluctant to demand forward-looking technical assistance, such as help in designing drug resistance surveys. This finding is supported by the Global Task Team report on technical assistance: “In many cases where implementation has been slow or sub-standard, the information deficit (on country’s technical assistance needs) is compounded by countries’ reluctance to engage in technical collaborations beyond support in the preparation of proposals for funding”<sup>3</sup>.

- Third, countries are unfamiliar with the kinds of technical assistance available beyond basic application support and training. They don’t know what to ask for, so aid arrives without countries’ input. Consequently, there is a lack of ownership. In Zambia, our interviewees expressed a belief that technical assistance is often pushed onto the country and draws on non-locals. Interviewees in Mozambique noted that the country has been given technical assistance that does not fit its needs.
- Fourth, most technical assistance takes the form of advice and reports with recommendations instead of the long-term, hands-on support countries need to fight diseases effectively. For example, in Laos, we heard that “GHPs tend to send people in for intense bursts of activity and leave reports with a lot of ‘shoulds’ but not a lot of ‘hows’.”
- Last, in-country development partners feel that they do not have the staff or funds to support GHP programs. In Vietnam, Zambia and China, for example, partners expressed concern about their ability to support an increasingly “unfunded mandate” for technical assistance. Furthermore, technical assistance needs to be backed by additional funds to revamp systems like M&E and lab infrastructure. However, funding substantial cross-cutting systems development is beyond the mandate or ability of any single GHP.

### *iii. GHPs have created too many inadequately structured country coordination forums*

In the past few years, numerous country-level coordination groups, committees and programs, particularly in the field of HIV/AIDS have been created. However, country interviews suggest that there is very little actual coordination to show for this proliferation.

First, every GHP wants its own coordination mechanism, but the roles and responsibilities of these coordinating bodies are not clearly defined. An interviewee in Mozambique said that GHPs did not take the time to understand other programs in order to prevent duplication. “PEPFAR does not ask, ‘What are you doing for [the World Bank’s Treatment Acceleration Project]?’” the official said, “so we do not go into that.”

In Angola there are many coordinating bodies, but none meet the country’s needs. In Tanzania there are at least four committees focused on HIV/AIDS, and although there is a clear division of labour, there is little communication between the groups. Activities occur as if the other committees do not exist. Similarly, in the Democratic Republic of Congo, four separate committees focus on HIV. Ugandan officials say they would rather have folded the Country Coordinating Mechanism (CCM) into an existing HIV committee rather than create an entirely new group.

Second, coordination meetings achieve little real progress. Country officials lack experience in running such meetings, and many countries hardest hit by the diseases GHPs fight lack experience with the good governance practices, like transparency, required to run effective meetings. Compounding countries’ limited experience with coordination meetings, countries also often have limited or non-existent budgets for basic administrative services. Moreover, because countries lack senior managerial expertise, the same people tend to serve on several coordinating bodies. For instance, in Burkina Faso, Tanzania, Bangladesh, Vietnam and Angola, we discovered that many of the same people who served on the CCM for the Global Fund served on the Interagency Coordinating Committee (ICC) for GAVI, and other national committees. These managers’ skills are spread too thin for them to be fully effective.

The costs of poor coordination at the central level wind up falling on front-line district health management teams. NGOs (including those funded by the GHPs) do not consistently share plans with or disclose finances to districts. In Zambia, for example, experts estimate that 50 percent of activities in the field are not known to national planners before they happen.

The situation is not completely dire, though. Many countries reported that the ICC functions better than the Global Fund’s CCM. The ICC has a narrower and less political scope, a clear operational



role beyond application submission to ensure that EPI targets are met, and greater flexibility in composition and meeting norms.

In addition, some countries are addressing the issue of proliferating coordination forums in innovative ways. The Kyrgyz Republic, for instance, is attempting to merge the CCM and an existing health coordination committee to form a new umbrella structure.

### **b. Countries are burdened with parallel and duplicative processes from multiple GHPs**

Interviewees told us that the “one size fits all” processes GHPs find tempting to impose on countries do not recognize their diversity, and that GHPs have trouble dealing with system-level issues.

#### *i. “One size fits all” processes do not recognize country diversity*

GHPs aim to support country efforts and processes, but they sometimes fall short. More often, GHPs overlay their processes on country processes. This “one size fits all” approach can duplicate and undermine a country’s processes in key areas:

**Planning:** GHP planning timelines are often different from those of countries. In Ethiopia, Vietnam, and Bangladesh, for example, interviewees told us that the clashing schedules have led to duplication, confusion and misalignment between proposals and plans. On balance, however, this is a cost countries are willing to accept given the magnitude of the accompanying funding and the infrequency of the planning exercise. Some have adopted a mid-year review process to assess new sources of funding. In Bangladesh for example, if GHP grants start in the middle of the annual operational health plan, the annual plan is changed mid-year to accommodate new funding and activities.

**Financing:** For the most part, GHP financing mechanisms are separate from country mechanisms. As a result of this separation, it is difficult for countries to track financial flows, plan medium-term expenditures and think about financing health sector priorities in a holistic manner. Some GHPs and donors do not finance through health baskets, while others finance outside of the government entirely. While separate systems are sometimes justified, separate mechanisms for financing through GHPs create fragmentation and increase the administrative burden in already resource-constrained environments.

**Monitoring & evaluation:** Officials often collect surveillance metrics for GHP-funded programs in a fragmented manner. These metrics are not consistently integrated into national systems, and consequently GHPs may be duplicating efforts to collect metrics (e.g., through NGOs). In Zambia, two of the four principal recipients of Global Fund resources are NGOs and do not currently share the metrics they collect for Global Fund programs with the National Statistics Program. Officials in the Office of Statistics report, “Collecting data outside of the national systems undermines our planning efforts.” Beyond disease-specific surveillance metrics, GHPs often require programmatic metrics. This type of monitoring can increase program effectiveness and foster a performance mindset. In some cases, though, GHPs do not align with the country on reporting formats and timing, even when the content is similar. Furthermore, writing reports and hosting missions takes up scarce capacity at the district level.

**Procurement systems:** Some observers report that GHPs have encouraged countries to use procurement systems that duplicate efforts and deplete resources, but in other cases GHP procurement systems have helped prevent gaps in service delivery (see Case study: Procurement systems in Burkina Faso, Bangladesh and Angola).

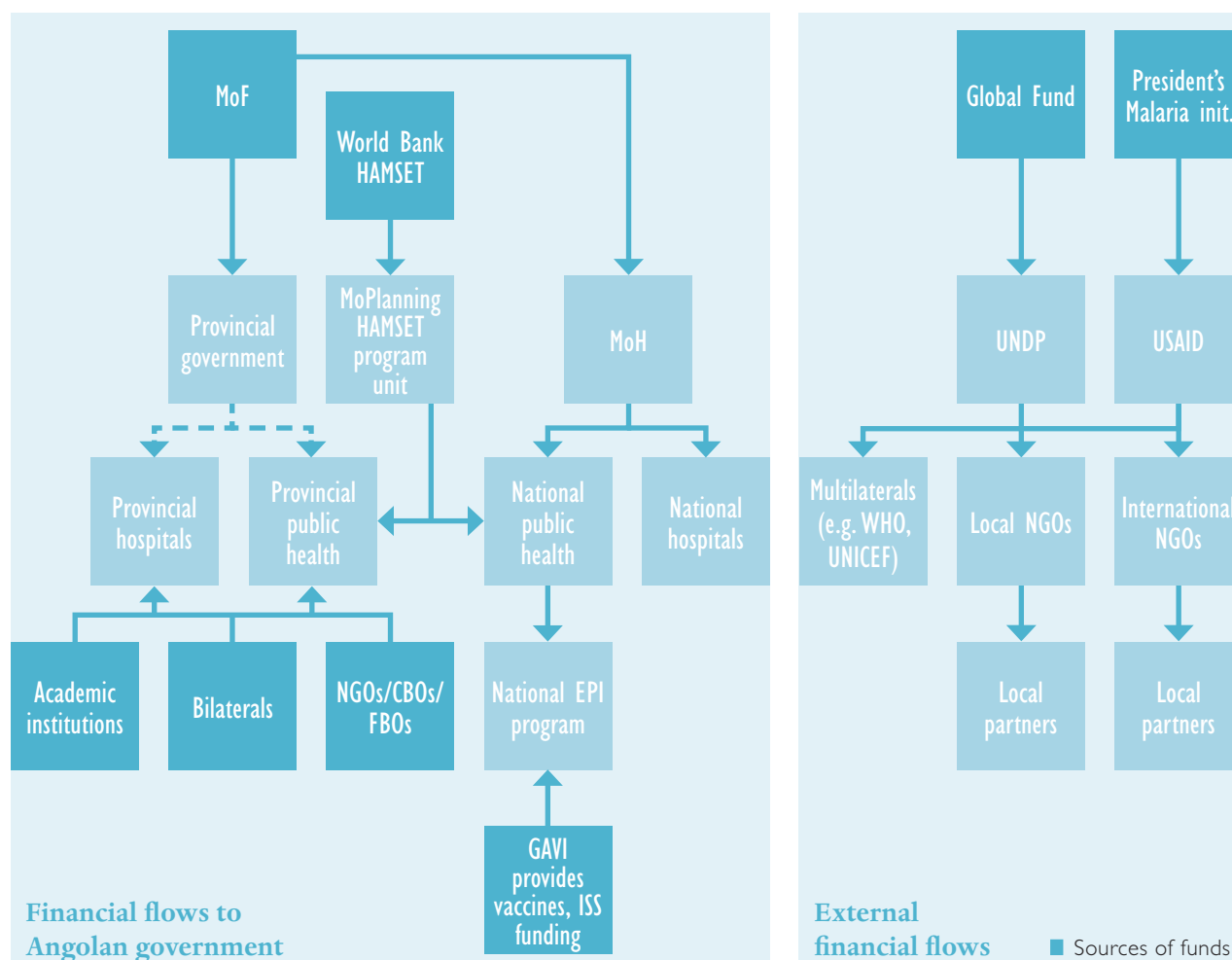
#### **Case study: Procurement systems in Burkina Faso, Bangladesh and Angola**

The government of Burkina Faso was rejected for two Global Fund TB grants because the Local Funding Agent (LFA) had concerns about the country’s procurement system. No formal feedback was available, and officials misinterpreted the rejections as a message that they were required to use the Stop TB Partnership’s Global Drug Facility (GDF) for procurement of TB drugs. Indeed, when Burkina Faso submitted a third application using the GDF for procurement, it was approved. Unfortunately, using the GDF reduced the country’s bulk purchasing power. In addition, after GDF drugs were delayed for several months (delivered mid-February 2005 rather than November 2004 as expected by the country), Burkina Faso had to dip into the health budget to replenish depleted stocks, creating a deficit of 3 to 5 percent for that year’s procurement budget.

Similarly in Bangladesh, after two unsuccessful Global Fund TB applications, the country believed it needed to procure TB drugs through the GDF. Even though Bangladesh had been procuring through the private sector, government officials are now dividing the supply chain between the GDF and the central procurement mechanism/private sector suppliers.

In cases where country systems are weak or non-existent, though, creating a parallel system may be warranted to reach program targets. Angola has succeeded in preventing the usual stock outs of TB drugs this year due to procurement through the GDF.

**Figure 1 Fragmentation makes tracking financial flows difficult, though partially justified by governance concerns**



- Donors have adopted a variety of routes to fund the health sector. Many do so because of good governance concerns in Angola.
- It is currently impossible for national or provincial level government to know how much money flows through its region because many donors work outside of the central MoF/MoH structure. Even if it had the capacity to do so, government cannot push donors to fund gaps or reduce duplicative activities. Also, it is difficult to think about sustainability when no one has a complete picture of the country's health financing.
- The proliferation of donors focusing on the same programs has also complicated funding flows (e.g. in addition to bilaterals, WB and Global Fund both fund HIV/AIDS, TB and Malaria – both through different routes (i.e. MoP and UNDP, respectively). Donors should consider focusing on their “comparative advantage”.

## ii. GHPs often stumble when dealing with system-level issues

The influx of GHP funding has highlighted challenges and gaps in country health systems, including problems with infrastructure, procurement, logistics, health information and financial systems and human resources. GHPs have not created these system-level issues. Addressing them is outside the core mandate of GHPs.

However, these issues do present serious barriers to realizing the full value of GHPs. Hence, GHPs such as the Global Fund and GAVI have started to address these system-wide gaps. Similarly, many GHPs are undertaking program-specific sustainability planning efforts, for both human and financial resources<sup>4</sup>.

These efforts do make sense for GHPs individually – but the cumulative effect of such efforts by multiple partners could overwhelm countries with weak systems for several reasons.

- First, countries often lack the necessary expertise or mechanisms to develop system level plans. A CCM member in China stated that “We did not submit a grant for health systems strengthening (HSS) because the CCM is divided into disease specific sub-committees for applications and there was no mechanism to create a broad HSS grant.”
- Second, GHP-led health systems strengthening could result in verticalization. A CCM member in Zambia noted that “We did not apply for HSS

funding in Round 5 because the Global Fund does not fund through basket/pooled funds and that is where we need support.” In Indonesia, we heard that the Stop TB Partnership’s efforts to strengthen lab diagnostic capabilities, M&E and drug management can have benefits for the broader health system, at least in theory. However, “the reality is that TB is still a vertical program and HSS is happening largely in disease-specific contexts.”

- Third, in the absence of sound technical assistance or planning mechanisms, GHPs may inadvertently encourage countries to develop HSS plans that are technically weak and too complex. An interviewee in Mozambique told us, “Don’t create a complex set of interlinked programs and call them systems strengthening.”

Any good sustainability plan must address human resources and funding. In both areas, GHPs encounter system-level issues.

- GHPs may be underestimating the human resources required for healthcare delivery to implement grants. Furthermore, the scarce managerial and administrative expertise available is sometimes consumed by program-specific project management units.
- In funding, the large gap between most countries’ current financial situations and the funding required to sustain GHP programs causes three problems. First, because sustainability planning discussions are held at the program-level and not at the health sector-level, plans may become ineffective. Second, because GHPs often provide support for only a three-year horizon, countries find it difficult to develop long term sustainability plans. Third, because multiple GHPs aim for countries to sustain the costs of programs after grants expire, the collective expense of these programs may be difficult for countries to bear. A Ministry official in Tanzania noted that, “In three years, we know that we need to take over the HepB vaccine. But in addition to HepB, we’re supposed to take over ACTs and ARVs. We can’t sustain the expense of all of them. ARVs alone will cost \$34 MM annually, which is one-third of Tanzania’s entire public sector budget.”

### c. GHPs have not communicated adequately and effectively with countries

Communication across GHPs, partners, and countries is deficient in two ways.

#### i. Countries have neither the power nor the appropriate channels to provide feedback to GHPs

One of the most common misunderstandings between GHPs and countries is the level of flexibility available for applications and plans. Most countries do not feel empowered to ask GHPs to tailor their approach. They never broach the topic. For example, a ministry official in Ghana told us, “We changed our SWAp [Sector Wide Approach] to accommodate the Global Fund. We did not think about asking them to change – that would be impossible.”

In some cases, country officials suspect that the GHP representatives in the country are not senior enough to discuss policy and flexibility issues. In Tanzania, for instance, donor partners were reluctant to approach the fund manager for the Global Fund given reservations about his influence or ability to change elements of that country’s Global Fund grant.

Some countries also reported that the time it takes for GHPs to respond to countries’ queries is not conducive to having a productive conversation. When countries don’t receive answers for months, they tend to make decisions on their own. In the Kyrgyz Republic, for example, confusion and slow communication about GAVI support for the pentavalent vaccine resulted in the government turning down GAVI support except for some safety supplies.

Perhaps the worst result, though, is that poor communication leads to the propagation of myths about GHP policies. One Asian country’s officials told us that GHPs consider African countries to be a higher priority than countries in their region. In Ghana, we heard that the country felt that GHPs “probably already knew which countries would receive money before anyone applied. They should have just told us that Ghana was not on the list – it would have saved a lot of effort that went into the application.” Similar myths about priority programs exist, including the perception that “The first grant was for HIV/AIDS because that is the biggest priority for the Global Fund. The next one was for TB. Now it is malaria’s turn.” None of this is true, but in the absence of good communication, countries don’t hear differently.

#### ii. Partners are unclear about their roles and responsibilities as they relate to GHP activities

GHPs tend to operate with lean central administrative staff and minimal or even no in-country staff. They reason that GHPs should harness the power of partnerships and not duplicate partner resources, since many of these partners have a country presence.

For the most part, however, countries express frustration in dealing with GHPs in the absence of a “country face.”

In-country partner agencies are not prepared to be the face of GHPs in the country for a variety of reasons.

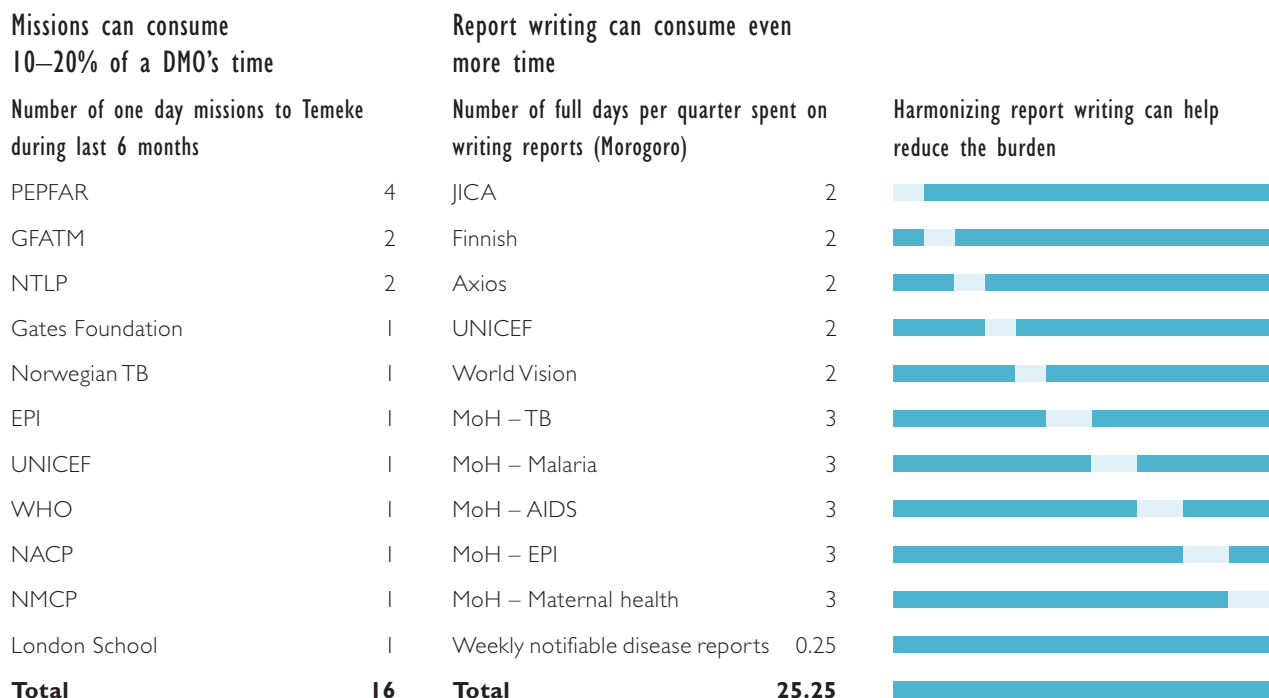
GHPs, for the most part, have not structured clear agreements about country interactions with their partners. Global-level memoranda of understanding have a limited impact in defining the role of partners on a country-by-country basis. While country agency staff support grants in some countries, our interviews found a growing sentiment that this support is often ad-hoc and depends on individual personalities to make it work.

GHPs also tend to rely on in-country development partners to provide technical assistance for GHP-funded programs. However, with the expanding scale of GHP-funded programs, country partners told us they lack the resources to support countries’ expanding technical assistance needs. One partner in Vietnam noted, “We are simply unpaid workers of GHPs like the Global Fund and GAVI. While

there is more and more work, our staffing capacity has not been increased at all. We do all this support because we are here to assist the country.”

Furthermore, country agencies feel as ill-equipped to work with GHPs as the countries themselves. For example, in-country WHO and UNICEF staff trying to help countries with GHP applications or programs often can’t answer key questions or even tell countries where to turn for help. For example, one interviewee from a multilateral agency said, “It was a slap in the face that the Global Fund originally wanted to sidestep working with UN agencies. . . . Now the Global Fund expects us to help with their programs, and it works in [this country] because the personalities here have made it work. . . . The UN agencies have tried to be a silent partner, but we’d love to see a formalized partnership with the UN agencies to articulate the specifics of what role each partner should play. We think it would be mutually beneficial.” In the absence of such clarity, GHPs run the risk of not harnessing the power of these partnerships and becoming yet another donor entity with a vertical program in the country.

**Figure 2 Hosting missions and report writing are major burdens at the district level**



We visited several districts in Tanzania to assess the burden of monitoring, evaluation, and report writing at the district level. Interviews conducted with the DHMT and visitor logs were scored.

It was found that report writing can take 40–50% of the time of the District Medical Officer. Reports written in the previous quarter in Morogoro District included a majority written for the Ministry of Health (over 60%). Hosting missions was an additional burden on DHMT time that could be spent implementation. In Temeke district, hosting missions absorbed 10–20% at the time of the DMO. Missions included those from PEPFAR, the Gates Foundation, the Global Fund, as well as multilaterals, research institutions, and bilaterals. Predominant reasons for missions included audits, evaluations, and assessment of new program feasibility.



We see this risk most clearly in the area of monitoring and evaluation. Few GHPs have been able to streamline the M&E requirements of partner organizations into one report. As a result, districts have to write multiple reports, taking health officials' time away from more pressing matters. (see box below).

#### Case study: The burden of monitoring and evaluation in Angola

Reports help donors know whether their programs are working, but they also add to the workload of in-country officers. In theory, GHPs should reduce this burden by streamlining reporting requirements, but in Angola, we found that for the Expanded Program on Immunization (EPI) officer, this is not the case.

The WHO/UNICEF Joint Reporting Form (JRF), the GAVI report, and Government of Angola EPI program monitoring form all track progress with immunization, and so the EPI officer is responsible for all three. The JRF uses some data from the country EPI report, but still requires additional indicators not tracked in the country system. The GAVI report has some overlap with the two reports for historical data but also focuses on financial data, projected immunization targets and qualitative progress.

This results in major differences in report formats for all reports. Furthermore, these reports are all due at different times.

### 3. Innovative practices and emerging opportunities to address the issues countries face when working with GHPs

While all the countries we surveyed face some of the issues raised in this assessment, the magnitude of the costs vary. Some countries are better at managing interactions with GHPs than others. Similarly, some GHP practices have helped mitigate costs and smooth interactions with countries.

#### a. What countries can do

In our research, we discovered that countries that work well with GHPs have a few defining characteristics:

- They have strong, integrated health plans.
- They have established funding mechanisms in which donors participate.
- They clearly establish the roles of central and district governments.

For example, in countries with strong plans – such as Vietnam, Bangladesh, the Kyrgyz Republic, China, Tanzania and Ghana – we found that GHP funding supported execution of an existing health strategy or brought focus to under-funded priorities

like HIV / AIDS. Such countries saw little or no distortion of existing priorities. In Mozambique, the government was able to work with the Global Fund to route funding through its existing, functioning, donor-supported SWAp. Countries such as Tanzania, Zambia, and Vietnam, where policies are set at the national level and action plans are determined at the district level in accordance with national priorities, were better able to fit GHP resources into their health activities.

In all these cases, leadership and management capacity have been crucial to creating positive outcomes.

In these countries, local knowledge and evidence allow country governments to independently plan, design and execute programs and hold a two-way dialogue with GHPs to ensure outcomes that are optimal for the country.

To leverage GHPs to reach health outcome targets, countries need to nurture their homegrown talent. It is critical to success.

#### b. Opportunities to reduce costs abound

We know GHPs operate in a tough and diverse environment.

- Developing country health systems are often inadequate and opaque.
- There are tensions with partners at global and country levels.
- Country situations vary significantly.
- Multiple priorities compete for scarce leadership, management time and resources.

Despite the challenging environment, we believe there are several opportunities – within the control of GHPs – to reduce the costs they impose on recipient countries while retaining the benefits they create. In fact, many of the opportunities suggested below come directly from country stakeholders. The High Level Forum to advance Health Millennium Development Goals could make these opportunities part of a monitored action plan for GHPs.

To reduce costs, there are steps that GHPs can take both individually and collectively. GHPs can:

##### i. Ensure GHP funding is accompanied by the resources required for implementation

**Address shifts in policy and technology:** The pace of policy and technology shifts will only accelerate in the coming years. These shifts are pivotal but difficult events for countries to manage and will have long-term ramifications for countries' health outcomes. To achieve their policy goals, GHPs must,



over the long-term, let countries lead discussions on the optimum timing, pace, and scale of new technology adoption. For instance, instead of immediately adopting ACT therapy for malaria, as GHPs pushed, some countries might have phased in ACT use, focusing on the neediest districts first.

**Provide adequate implementation support:** Countries shoulder the costs of implementing GHP programs, so GHPs should allow countries to include overhead costs in their grants. This will allow countries to build the management capacity and technical infrastructure needed to implement grant activities. GHPs could suggest what portion of a grant would be appropriate for implementation and infrastructure support. Encouraging countries to explicitly budget for and access support will stimulate demand for such assistance.

Collectively, GHPs should collaborate to develop an easily accessible database of providers of technical assistance and technical solutions. These providers should have expertise across diseases, health systems, geography and solutions areas (e.g., installing and upgrading health IT systems, opening new clinics and designing patient-advocacy campaigns). The database should contain experience profiles and track records.

True collaboration means sharing best practices. GHPs should create a knowledge management tool to share information across countries, regions and partners - a service that several countries have asked for.

Make country level coordination effective, particularly in the area of HIV/AIDS: GHPs active in HIV/AIDS are responsible for addressing the lack of meaningful coordination in this disease area, and must be held accountable for the resulting costs for countries. GHPs and other international HIV/AIDS initiatives can help by providing tangible support for coordination mechanisms. This includes facilitating meetings or workshops, establishing communication norms, and earmarking part of the grant to support the coordination mechanism's activities. This can be led by an in-country partner or supported by GHPs' administrative teams. In addition, GHPs should develop memoranda of understanding between partners in coordination mechanisms that clarify roles and responsibilities.

*ii. Design processes and systems so they complement each country's own processes and systems*

Realize "one size fits all" processes don't work: GHPs must tailor their approaches, requirements

and processes to work better with specific country health systems. Most GHPs do want to strengthen and work through existing country systems, and several are doing just that. They are using continuous funding cycles or funding system wide approaches. They are changing their mindsets to "becoming the best provider" instead of "not being the worst offender." Specifically, GHPs need to be flexible with countries, and let countries know that, if they achieve a good track record and develop strong health systems, flexibility is an option in areas including:

- Frequency of and level of detail in grant applications
- Grant size
- Use of existing country systems and timelines in areas like planning, monitoring and evaluation, procurement or coordination
- Pace of ramp-up and duration of support for sustainability planning
- Nature of interactions with central, state and district-level decision makers

We understand that tailoring processes, while helpful, will exacerbate the challenges of communication by making the rules less clear for both countries and potentially for GHP partners. Hence, GHPs will have to communicate the boundaries of flexibility and establish clear standards for country interactions with GHPs.

Moreover, GHPs should use technical assessments to provide concrete feedback to countries. This feedback could address areas such as procurement systems and HR capacity. Transparent feedback will help countries decide where to invest in system improvements. Stronger systems, in turn, will allow GHPs to be more flexible.

Stop duplicating efforts:

- GHPs need to collaborate to ask countries for one unified multi-year health sector plan. This plan would cover priorities, programs, infrastructure requirements and expected financial flows and funding. This plan should cover all health sector actors including the national health system, the private sector and NGOs.
- Countries and GHPs should evaluate alternative models of funding health system strengthening instead of individual GHP efforts. For example, countries could incorporate overhead charges in individual grants to fund shared health system investments.
- Collectively, GHPs should reduce the burden of missions and reporting by creating a single

unified mission for all partners in a disease area, and creating one unified report for country officials to complete.

*iii. Improve communication with countries*

Boost communication between GHPs, partners and countries: Delayed and patchy communications dilute program quality and create a negative perception of GHPs. Fortunately, GHPs can change this quickly. They can:

- Increase the size and quality of GHP global level administration to ensure prompt and qualified dialogue with countries on administrative and technical topics. This would allow GHPs to

establish basic norms for communication (e.g. promise to answer queries in three days and resolve issues in 30 days).

- Clarify when partners are the face of the GHP. Because countries do not know when a partner represents the GHP and because partners don't fully align their policies and technical support with relevant GHPs, countries look to global level administrators for information and support when they could ask questions closer to home. To this end, GHPs should develop country-specific memoranda of understanding with lead partners about local planning and implementation activities that make roles and responsibilities clear.

# BEST PRACTICE PRINCIPLES FOR GLOBAL HEALTH PARTNERSHIP ACTIVITIES AT COUNTRY LEVEL

By Karen Caines, Paris, November 2005

## I. Introduction

The High Level Forum on the Health MDGs (HLF) in December 2004 in Abuja held a session on Global Health Partnerships and Funds (GHPs). It identified the need for action to:

- review cross-cutting issues and identify opportunities for synergies and harmonization between different initiatives and partnerships
- support further analytic work (building on studies and evaluations already carried out by DFID and its Health System Resource Centre, the World Bank, the European Commission and DAC) to provide greater clarity about guiding principles and actual practices, draw out lessons about best practice, and support the development of common principles of engagement and systems for monitoring their application.

To consider these issues further, a High Level Forum Working Group on Global Health Partnerships was established to bring together representatives of recipient countries, donor countries, partnerships, foundations, and multilaterals. It met twice, in April and September 2005.

It concluded that a new country-level study would add value to current knowledge. The Bill and Melinda Gates Foundation was already commissioning a study of GHPs to be undertaken by McKinsey & Co. who have since surveyed 20 countries and undertaken field visits to six. The study provides an up to date assessment of the country-level perspective on global health partnerships and initiatives. It focuses on the transaction costs at country level of multiple GHP interactions (on top of existing donor communities), in the context of the benefits provided by GHPs.

The Working Group examined the relevance of the Paris Declaration on Aid Effectiveness for the health sector generally and GHPs in particular. In the light of previous studies of Global Health Partnerships and provisional findings and conclusions from the McKinsey & Co. country study, it noted a gap between these internationally-recognised prin-

ciples of effective aid and the practice of major GHPs at country level. It therefore developed proposals for best practice principles for GHP activities at country level and their follow-up, with examples of practical implications and enabling actions required from other parties.

Global Health Partnerships (GHPs) have a major role to play in scaling up priority health interventions and investments, improved health outcomes and faster progress towards achieving the health and poverty reduction MDGs. Indeed, a key reason for establishing such partnerships and funds stemmed from global concern about the growing burden of disease pandemics, particularly in Africa, and the need to accelerate action substantially if global targets were to be achieved. A fundamental strategy of GHPs has been to work in new ways to expand effective collaboration – including promoting greater participation by civil society and the private sector – and increase access to resources to serve those in need.

Overall GHPs have contributed many benefits. The major GHPs have been instrumental in advocating for, or providing, large-scale new financing. They have raised the profile of their target diseases at the highest political levels globally and nationally. Other key areas of success have been to accelerate progress; attract new partners and increase the profile of non-governmental stakeholders, including NGOs and the private sector, in the global fight against specific diseases; provide a means of supporting global public goods; secure substantial economies of scale (eg in drug procurement); and in some cases lead innovation. Development of a clear strategy, building a consensus around it, and coordinating partner efforts are fundamental added-value objectives for technical GHPs.

At the same time, the proliferation of global health partnerships and funds over the last few years – alongside traditional donor activity – has raised new issues. GHPs are highly diverse in nature, scope and scale, and any attempt to compare them with the same yardstick has considerable limitations.

Most are relatively small or very specialised. The main concerns at country level relate to a few major global health partnerships. Overall the collective impact of GHPs has created or exacerbated a series of problems at country level including: poor coordination and duplication among GHPs; high transaction costs to government and donors from having to deal with multiple initiatives; variable degrees of country ownership; and lack of alignment with country systems. The cumulative effect of these problems is to risk undermining the sustainability of national development plans, distorting national priorities, diverting scarce human resources and/or establishing uncoordinated service delivery structures.

In addition, without increased support to help build health system capacity in almost all developing countries, the resources mobilised by global health partnerships and initiatives are unlikely to achieve their full potential. Longer-term there will be need to sustain the achievements realized through shorter-term support from GHPs.

Evidence from studies of GHPs<sup>1</sup> suggests a gap between the overall practice of GHPs at country level and internationally-recognised principles of effective aid, as set out most recently in the Paris Declaration on Aid Effectiveness (March 2005). Successful scaling up will require more aligned and harmonised approaches (for example, in relation to GHP application procedures, transfer of funds, management, monitoring, reporting and auditing).

There are opportunities within the control of GHPs to make changes in their approach and processes to reduce the costs they impose on recipient countries. Most of the Paris Declaration principles are already being practised by some GHPs in some countries – which suggests that there may be challenges but no insuperable barriers. Yet no single GHP appears to practise all in all environments. A key message for GHPs is the importance for them to act with speed and flexibility:

- to endorse and enact some best practice principles for the engagement of GHPs at country level, primarily relating to alignment and harmonisation, in the belief that better harmonized and aligned aid from GHPs will ultimately lead to better results; and
- to work with countries, and with other agencies and GHPs, rapidly to get in place solutions to the simpler problems raised, while at the same time developing approaches to the more challenging problems.

Draft best practice principles have been derived from a GHP-specific adaptation of the five key areas of the Paris Declaration on Aid Effectiveness:

- **ownership:** *GHPs respect partner country leadership and help strengthen their capacity to exercise it;*
- **alignment:** *GHPs base their overall support on partner countries' national development strategies, institutions and procedures;*
- **harmonisation:** *GHPs' actions are more harmonised, transparent and collectively effective, and GHPs collaborate at global level with other partners to address cross-cutting challenges such as health system strengthening;*
- **managing for results:** *GHPs work with countries to adopt and strengthen national results-based management*
- **accountability:** *GHPs provide timely, clear and comprehensive information.*

In addition, a few best practice principles on GHP governance are proposed. In the interest of public accountability, GHPs should ensure that their purpose, goals and objectives are clear; procedures are transparent; and key documents should be publicly available on the internet.

If best practice principles are agreed, the intention is to move forward swiftly to practical action. Further work in collaboration with individual GHPs is required to explore fully the implications for GHPs of operationalizing the best practice principles, which are likely to be different for each GHP. The full paper lists examples of the kinds of issues that are likely to emerge.

Given the need to tailor approaches to different settings, these principles are primarily to be operationalized at country level. Countries may wish to set their own targets and indicators. There is scope for the development of country-level mechanisms to support compliance through country-specific agreements between all partners on rules of engagement.

An issue-focused global forum should be held on a regular basis to provide an opportunity for key players from major GHPs, recipient governments and donors to review principles, practice and progress; and address issues of joint concern, including overlaps, gaps and systems issues. Ideally such a discussion would take place within the wider context of taking stock of developments in the health sector as a whole.

If best practice principles are adopted, follow-up action from GHPs should include a self-assessment



of individual GHP practice in relation to the principles; development of proposals for action; and consideration with countries and other partners of those wider issues needing collective action.

Enabling action will also be required from other partners, including countries, and bilateral and multilateral agencies.

## 2. Health and the OECD/DAC Paris Declaration on Aid Effectiveness

### a. The Paris Declaration on Aid Effectiveness: General

Global Health Partnerships operate within a wider health and development context. Best practice principles for GHPs should be set within the framework of existing agreements to streamline, harmonise and strengthen development cooperation.

As early as the 1980s, there was concern that a proliferation of donor projects (combined with differences in donor policies, operational procedures and reporting mechanisms) were hindering the effectiveness of aid, creating an unsustainable administrative burden on countries and reducing local ownership. Recognition of these problems led to the emergence, in the late 1980s and early 1990s, of budget support, sector-wide approaches and Poverty Reduction Strategy Papers (PRSPs). These new approaches were guided by the idea that aid should be provided more flexibly; that government (rather than donors) should set priorities and allocate resources; and that the transaction costs of aid should be reduced.

The movement towards better aid resulted in two *High Level Forums on Aid Effectiveness* – in Rome in February 2003 and Paris in March 2005. Donors and partner countries defined the ‘aid effectiveness’ agenda and committed to implementing it. At Rome, donors agreed (among other things) to ensure that development assistance is delivered in accordance with partner country priorities, including poverty reduction strategies; reduce the number of missions; streamline conditionalities; and simplify and harmonize reporting procedures.

Earlier this year in Paris, a new Declaration on Aid Effectiveness was issued which moved the agenda on by adding indicators and targets to the commitments. It has the support of over 100 developing and donor countries, and organisations including the African Development Bank, Asian Development Bank, European Bank for Reconstruction and Development, Inter-American Development Bank,

Development Assistance Committee of the OECD, UN system organizations (through the UNDG), and the World Bank.

The five key areas of the Paris Declaration are:

- i. **ownership:** *partner countries exercise effective leadership over their development policies and strategies, and coordinate development actions*
- ii. **alignment:** *donors base their overall support on partner countries’ national development strategies, institutions and procedures*
- iii. **harmonisation:** *donors’ actions are more harmonised, transparent and collectively effective*
- iv. **managing for results:** *managing resources and improving decision-making for results*
- v. **mutual accountability:** *donors and partners enhance mutual accountability and transparency for development results and the use of resources.*

‘Alignment’ refers to efforts to bring the policies, procedures, systems and cycles of the donors *into line with those of the country* being supported, and ‘harmonisation’ refers to efforts to streamline and coordinate approaches *among donors*.

Within these five areas, the Paris Declaration has some 50 commitments to improve aid quality, involving action by both donors and partner countries. These will be monitored by twelve indicators and specific targets for the year 2010 (set out in Annex 1).

Examples of targets for 2010 include:

- at least 85% of aid to be reported on government budget(s);
- 66% of aid flows to be provided through programme-based approaches;
- 40% of donor missions to the field, and 66% of country analytic work to be joint;
- parallel project implementation units to be reduced by two-thirds.

### b. The significance for health<sup>2</sup>

From a health perspective, the move towards more streamlined and predictable donor support has a number of implications. For example:

- The concept of country ownership over development policies and poverty reduction strategies should extend to the health sector. This has two aspects: first, health sector plans should be country-owned and developed. There remains, however, a role for development partners (including GHPs) to challenge and help strengthen country plans which do not adequately prioritise the health needs of the poorest people. Second,



health ministries should engage in framing ‘upstream’ development strategies, as these impact on (for example) health workers’ pay and sector budget ceilings. There is need therefore to build capacity within ministries of health to engage with ministries of finance and planning, and with poverty reduction strategy (PRS) processes. Ideally the PRS should build on a sound health sector plan and expenditure framework.

- Development assistance for health should be aligned with national systems, including health service delivery systems; information and monitoring systems; and national procurement systems. Multi-year commitments on aid flows are essential if countries are to make sustainable plans to scale up health provision, for example by employing more health workers or beginning long-term treatment programmes. Multi-year commitments on budget support are seen by many as a way of increasing predictability. However, as donor support moves upstream, it will be important to maintain government-partner dialogue to ensure that health remains a priority within overall development efforts, and that improved health service delivery and better health outcomes are being achieved.
- Harmonisation and simplification of donor practice are particularly important to the health sector, which is typically characterized by a large number of actors (bilateral, multilateral and GHPs), many with a particular disease or age focus (eg malaria, or child health). At present, coordination mechanisms in health are highly variable from country to country.
- Improved, accessible information is key to measuring performance and ‘managing for results’. There is need to strengthen health information systems, particularly in low-income countries, and to agree on a set of process indicators that can help policy makers assess health system performance.
- Innovative approaches to strengthen direct accountability between health providers and clients are needed, as well as mutual accountability between donors and partner countries. Experience is needed of effective ways to tackle corruption, fuelled by low pay and constrained resources in the health sector.

The Declaration is already providing at least part of the context for other relevant action in the health and related sectors, for example the work of the UNAIDS’ *Global Task Team on Improving AIDS*

*Coordination Among Multilateral Institutions and International Donors* which reported in June 2005<sup>3</sup>.

### 3. Paris Declaration commitments and GHP practice at country level

This section identifies target GHPs and provides a general overview of findings on GHPs from recent studies. It then examines study evidence about GHP practice at country level in relation to the main areas of the Paris Declaration commitments: ownership, alignment and harmonisation (with relevant indicators like aligning aid flows on national priorities, using country systems, avoiding parallel implementation units and making aid more predictable), managing for results, and accountability.

#### a. Target GHPs

Estimates suggest there are from 75-100 GHPs, depending on definition. The main types have been classified as:

- *research and development*: GHPs involved in product discovery and development of new therapies (vaccines, treatments etc.);
- *technical assistance/service support*: GHPs providing drug donations, support improved service access and/or give technical assistance;
- *advocacy* (national and international levels): GHPs advocating for increased international and national response to specific diseases, fundraising for specific control programmes etc.
- *financing/funding*: GHPs providing funds for specific programmes.

They are highly diverse in nature, scope and scale, and any attempt to compare them with the same yardstick has considerable limitations. Most are relatively small or very specialised.

Studies suggest that the main concerns at country level relate to a few major global health partnerships (GFATM, GAVI, the Stop TB Partnership and Roll Back Malaria). Most either channel significant resources and/or coordinate major health partners in key areas.. Two further Partnerships – the Health Metrics Network and the Partnership on Maternal, Newborn and Child Health – are too new to provide country-level evidence but are likely to form part of future collaboration among major GHPs. There are significant differences in function and operation between GHPs providing funding (GFATM and GAVI) and those concerned with coordination, advocacy and technical support (Roll Back Malaria

and the Stop TB Partnership). Proposals for best practice principles would, however, have relevance to all global health partnerships.

## b. General overview of findings on GHPs from recent studies

Overall most studies agree that GHPs have contributed many benefits. The major GHPs have:

- been instrumental in advocating for or providing large-scale new financing;
- raised the profile of their target diseases at the highest political levels globally and nationally;
- accelerated progress (though it remains unclear whether some GHP targets will be delivered on time);
- attracted new partners and increased the profile of non-governmental stakeholders, including NGOs and the private sector, in the global fight against specific diseases;
- encouraged the use of evidence-based approaches to public health (such as harm reduction and substitution therapy) which may be neglected by governments;
- provided a means of supporting global public goods;
- secured substantial economies of scale (eg in drug procurement); and
- in some cases led innovation.

Development of a clear strategy, building a consensus around it, and coordinating partner efforts are fundamental added-value objectives for technical/coordination GHPs.

A study currently being finalised by McKinsey and Co. provides up to date evidence of findings at country level<sup>4</sup>. Given the speed of developments, most findings in this paper are drawn from its provisional report unless specified otherwise. The study agrees with earlier work that GHPs are achieving their goal of increasing focus and activities on specific health priorities that may have been marginalised or under-resourced.

Besides getting much-needed attention and funding to fight diseases, countries have benefited from GHPs' interactions in a variety of ways. For example, GHPs' requests have caused countries to increase planning capacity and GHP feedback has helped countries craft robust plans for key diseases. Countries have strengthened the rigour of programme monitoring and improved accountability for use of funds and overall transparency.

At the same time, there is a striking consensus among recent multi-GHP studies that – alongside the many important contributions made by GHPs – their collective impact has created or exacerbated a series of problems at country level. For example:

- **poor coordination and duplication** among GHPs and with other agencies. For example, several GHPs – in addition to multilateral and bilateral agencies – are undertaking programme-specific sustainability planning for both human and financial resources.
- **high transaction costs** to government and donors from having to deal with multiple initiatives.
- **variable degrees of country ownership;** and
- **lack of alignment** with country systems.

The cumulative effect of these problems is to risk undermining the sustainability of national development plans, distorting national priorities, diverting scarce human resources and/or establishing uncoordinated service delivery structures. This has been a long-running concern and GHPs have made efforts to minimise transaction costs. Even so, the most recent study still finds that there are multiple opportunities for GHPs to reduce the burden on countries further. Countries also have opportunities to improve the way they deal with GHPs.

Delayed, patchy and weak communication between some GHPs, countries and partners can seriously dilute program quality and create a negative perception of the GHP. In some cases, countries have faced delays in getting clear feedback, advice and technical assistance from the GHP headquarters. The rationale for policy and technology shifts has not been sufficiently communicated. The problem may stem in part from the emphasis on GHPs operating with lean secretariats. In-country partner agencies are not always prepared to be the face of the GHP in the country, and conversely some GHPs are not always comfortable about being represented by partner agencies.

The influx of money from GHPs has highlighted existing problems in the basic health systems in many recipient countries. Without increased support to help build health system capacity in almost all developing countries, the resources mobilised by global partnerships are unlikely to achieve their full potential. Critical components include prevention, system capacity building (reflected most dramatically in shortages of professional health workers), surveillance, research, monitoring and evaluation, other essential public health functions, and the

role of non-health sectors. GHPs are now planning to put substantial funds into systems building, but their plans and activities need to be coordinated within wider national and global efforts rather than creating a multiplicity of individual GHP efforts.

GHP programmes may under-estimate the human resources required to implement grants, although this may be changing. In a recent application to the GFATM from the Democratic Republic of the Congo, only 5% was allocated to human resources; this subsequently increased to 20% when UNDP as the Principal Recipient requested a reallocation of the budgets. There is also an acute shortage of skilled managers. In these circumstances, GHPs often attract scarce talent from government activities, and the cumulative impact of GHPs amid multiple partners in-country may well overwhelm countries. In some cases, GHPs have allowed significant salary inflation to occur, particularly for programme managers. This undermines countries' ability to deal with retention, and can become even more problematic if donors escalate salaries to compete with each other for talent, as has happened in Viet Nam and Cambodia.

While GHPs have mobilised technical assistance to help countries prepare applications for funding, post-application technical assistance is neither well-articulated by countries nor well-supported by partners. Inadequate funding of technical support for implementation – as well as management capacity to execute and oversee scaled up programmes – is a real threat to countries' ability to meet performance measures. In the short-term, there is increased and urgent demand at country level for aligned and harmonised technical assistance for implementation. Coordinated and expanded support is needed from throughout the UN system. There is also a role for foundations and the private sector. All technical assistance should be demand-led by countries and capacity-building in nature. The long-term aim must be to develop good quality competence and infrastructure at country level, with diminishing need for external assistance. This is likely to run beyond the scope of individual GHPs and require an institutional base.

In general, these cross-cutting system-level issues have neither been directly caused by GHPs nor are they unique to GHPs. Solutions will require collective consideration and action from a broader set of stakeholders. It is imperative upon GHPs both to help build country ownership of health programmes and support development of country systems, and

to work with others to address key challenges, for example in relation to human resources.

### c. Ownership

National ownership is fundamental since national partners are accountable to their own societies for the services they provide. As a matter of principle, GHPs need to ensure that their activities are coherent with national development strategies, as well as sectoral strategies.

Equally, national development plans should acknowledge the contribution of GHPs to achieving health sector goals. GHP activities often involve a wide stakeholder group (including civil society, private sector and government), which is in line with commitments to increase participation in national development strategies.

In practice, studies suggest variable degrees of country ownership. For example, the recent *Final Report of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors* found that progress towards realizing this vision of national ownership has been uneven, hindering progress towards realisation of the 'Three Ones' principles for AIDS<sup>5</sup>. It judges that relatively few of the existing national AIDS strategies meet the requirements of one national AIDS action framework, as defined within the 'Three Ones'.

Conversely there was little evidence of international partners supporting nationally-owned plans and policies, and ensuring that their own activities are included in national plans. The Global Task Team report challenges countries to secure ownership by developing capacity to identify problems, set priorities and establish accountable systems to enable the rapid scaling up of a multisectoral response to AIDS. It also challenges multilateral institutions and international players (which include relevant GHPs) to be accountable for providing support to national plans, policies, procedures, systems and cycles, including through aligning with them and harmonising with each other. The underlying principles would apply equally to GHPs in other health areas.

National coordination of GHPs is the key to better performance, for which capacity to manage external partners is critical. There are several countries that exemplify how this can be done effectively. However, there are others where the institutions of government function poorly or are on the point of collapse. Strategies for better co-ordination in these circumstances require attention.



The GFATM, through its Country Coordinating Mechanisms (CCMs), is frequently cited as having increased the involvement of the private and civil sectors, and improved transparency. Countries are piloting innovative ways of strengthening coordination bodies.

Overall however, countries are seeing a surfeit of coordination mechanisms, with little effective coordination to show for it. The costs of poor coordination at the central level fall on the districts at the front line of execution. NGOs (including those funded by GHPs) do not consistently share plans with districts, nor disclose finances. The McKinsey study notes an estimate that in Zambia, 50% of activities at district level are unplanned, mostly as a result of NGO activities.

In Burkina Faso, Tanzania, Bangladesh, Viet Nam and Angola among other countries, many of the same people are stretched across the main coordinating bodies, including the CCM for the GFATM and the Inter-Agency Coordinating Committee (ICC) for GAVI, in addition to various national committees. Many countries report that ICCs function better than CCMs, perhaps because of their more limited scope, clear operational role beyond application submission, and lack of formality. Despite the 'Three Ones', HIV/AIDS has seen a proliferation of coordinating bodies and national bodies where HIV/AIDS is a major agenda item, with little evidence of increasing coordination.

#### **d. Alignment and harmonisation**

The current multiplicity of disease-specific GHPs, together with the activities of traditional international organisations (which are a mix of disease-specific and system-wide interventions), carry high transaction costs for developing countries. GHP requirements – for preparing proposals, reporting progress, procuring supplies, or in terms of institutional arrangements – differ significantly from programme to programme. A particular feature of some GHPs has been their pressure on countries to respond urgently to a very tight timeframe.

The technical/coordination GHPs already provide a vehicle for harmonisation in relation to their specific disease. Among the first products of the coordinated work of country authorities, donors and technical partners coming together as the Stop TB Partnership were DOTS Expansion Plans – generally formulated as part of larger 2-5 year development plans of Ministries of Health – and the Global Plan to Stop TB 2001-2005, (shortly to be succeeded by the Global Plan to Stop TB 2006-

2015). Similarly the Roll Back Malaria Partnership has this year produced a Global Strategic Plan 2005-2015 to coordinate partners' activities, and a small task team is preparing proposals for discussion at a global RBM forum in November 2005.

However, there remains scope for greater harmonisation and collaboration across GHPs, including the smaller GHPs. There is already an initiative to secure greater integration of GHP programmes for schistosomiasis, lymphatic filariasis, trachoma, onchocerciasis, intestinal helminths, and the micro-nutrient initiative, in countries in which they are co-operational.

#### **e. Aid flows are aligned on national priorities**

The rationale for the creation of GHPs was precisely to focus attention on specific areas regarded as requiring greater attention by partners acting in concert at the global level. Both stimulated and accompanied by effective advocacy programmes, GHPs have led to a major increase in resources for communicable diseases.

The issue of the extent to which GHPs are aligned on, or distort, national priorities has been a matter of vigorous debate not fully resolved by past studies. The current McKinsey & Co. study describes a distinction between countries based on the strength of their health plan (which may itself be an indicator of institutional capacity in the health sector).

In those countries where a strong health plan exists and is utilised, (for example, Viet Nam, Bangladesh, Kyrgyzstan, China, Tanzania and Ghana), priority areas have not been affected by the availability of additional funding. In some cases, the influx of HIV/AIDS funding has increased the priority given to the disease where countries might otherwise ignore it. For example, in Bangladesh the team heard that "given the social stigma of HIV/AIDS, government will to address the potential health epidemic would not exist in the absence of donor funding and focus on the disease". Moreover, the study found that countries set incoming funding against execution of their health strategy.

In other – often resource-scarce – countries with weak health plans, (for example, Chad, the Democratic Republic of the Congo, Angola, Cambodia, Zambia, Guinea and Laos), the limited capacity in-country is drawn to areas with financial resources, such as HIV/AIDS. In these countries, there is no spill-over from funded areas into other areas. Areas such as maternal and child health remain highly under-resourced, despite need. The Partnership on

Maternal, Newborn and Child Health is too new for impact yet to be seen at country level. In Chad, for example, while active diversion of resources is not occurring, donors' lack of focus on certain health areas reinforces their low prioritisation. Furthermore, even where areas of GHP activity are prioritised, lack of resources can result in fragmented implementation (for example, in relation to malaria control in Zambia).

Overall, some countries seem better able to work with GHPs, withstand shifts in priorities and handle some of the associated transaction costs. Contributory factors include the existence of a strong, integrated health plan; an established funding mechanism in which donors participate; and the clear delineation of roles between central and district governments. Countries in which policies are set at the national level and action plans determined at the district level in accordance with national priorities (for example, Tanzania and Viet Nam) are better able to fit GHP resources into activities.

This reinforces the wider need for GHPs and donors to help strengthen country processes, especially an integrated health plan. Where GHPs require applications (most notably the GFATM), the application process itself – though it can be time-consuming and intense – has often led countries to develop or strengthen health plans.

GHPs often explicitly or implicitly tie policy recommendations to grant-making, with some negative consequences. In some cases, countries perceive that they have been encouraged to replace policies that were most appropriate for them, given local financial and health system considerations. More generally, communication about policy rationales and GHP flexibility seems poor, and new technology adoption is not well-supported. Potential funders need to announce their policies earlier and more consistently so that countries can plan appropriately (ie, both for programmatic and financial sustainability purposes). GHP new technology requirements include GAVI pentavalent/Hep B vaccine; Stop TB Partnership/Global Drug Facility 4-drug combination product; PEPFAR FDA-approved antiretrovirals; and GFATM support for artemisinin combination therapy (ACT) only where indicated by WHO guidelines.

## f. Use of country systems

Alongside the push for better health outcomes, much of the global debate around GHPs has been about the need for alignment and harmonisation at the country level, in order to reduce the burden

on countries from multiple, parallel financing, planning, management, procurement and reporting systems and secure better health outcomes.

Most GHPs do profess to want to strengthen and work through existing country systems but this is not the case in practice. GHPs have often overlaid a standard set of their practices on countries (NB this is likely to apply mostly to the funding GHPs, especially the GFATM). This results in duplication of effort and undermining of country processes. GHPs must continue to tailor their approach, requirements and processes to better reflect country capacity.

*Planning:* GHP planning timelines and scope differ from those of the country, for example in Ethiopia, Viet Nam and Indonesia. This leads to duplications, confusion and misalignment between proposals and plans. On balance, this is a cost countries are willing to accept given the magnitude of the accompanying funds and the infrequency of the exercise. Some countries have adopted a mid-year review process to assess new sources of funds and resources that come outside their planning cycle (eg in Bangladesh).

*Financing:* For the most part, financing mechanisms for funding GHPs are still separate from the country's mechanisms, leading to planning complexity and administrative costs in tracking funds. While there are circumstances which justify separate systems (eg governance concerns, a budget ceiling for health, or funding for the private or NGO sector), separate mechanisms for financing through GHPs creates fragmentation. For example, in Angola where there are concerns about lack of good governance, it is currently impossible for national or provincial level government to track financial flows, since donors have adopted a variety of routes to fund the health sector. The proliferation of donors focusing on the same programmes but through different financing routes has further complicated funding flows. Thinking about sustainability is also difficult when there is no complete picture of the country's health financing.

Several GHPs are experimenting with proposals to adapt processes to the needs of individual or segments of countries e.g. continuous cycles, funding SWAs and baskets. But overall the McKinsey study finds that GHPs are not adequately supporting country financial mechanisms. In those countries with Sector Wide Approaches (SWAs) with pooled funding, GHP participation remains very limited. The Global Fund, for example, has to date formally joined SWAs only in Malawi and Mozambique.



## McKinsey & Co. study findings: GHPs are not adequately supporting country financial mechanisms

Country	Country mechanism	GHP outside mechanism
<b>Bangladesh</b>	SWAp (HNPSp) with >80% of budget from government and donors falling under single financial and reporting system. GHPs funding equals 2.5% of budget but each GHP adds reporting requirements.	GAVI GFATM
<b>Burkina Faso</b>	Emerging SWAp – PADS – integrates single report for all donors and provides decentralised funding to districts. Limited GHP engagement with districts.	GAVI GFATM
<b>Mozambique</b>	Established SWAp with 10 major partners, including GFATM, contributing to common fund with single reporting system.	GAVI PEPFAR

A GFATM report on Harmonization of Global Fund programs and Donor Coordination provides four case studies with a focus on HIV/AIDS<sup>6</sup>. They describe action to improve harmonisation and alignment, but also the reality of the challenges. For example, in Mali a broadly representative body (HCNLS) has been established to take responsibility for leading the country's multisectoral response to HIV/AIDS, and its role as Principal Recipient for three large HIV/AIDS programmes has begun to show potential for alignment on the part of the World Bank, the GFATM and the African Development Bank. UNAIDS and other partners have provided funding to develop a common monitoring and evaluation (M&E) system and database. The GFATM expects to use the National Program for Social and Health Sector Development and HCNLS audit procedures at the end of the first year of its grant. Nonetheless, the study identifies challenges in ensuring that the common monitoring and evaluation system is fully implemented; aligning procurement and supply management plans; strengthening the capacity of the new HCNLS; and further defining the HCNLS' relationship with the CCM.

In Mozambique, joining the SWAp has prompted the GFATM to explore ways in which its requirements for assessments of Principal Recipient capacities, approval of procurement and supply management plans, audit reports, and monitoring and evaluation plans can be adjusted to use the mechanisms already established by the SWAp.

The overall conclusion is that GHPs should be working towards much greater use of national systems for disbursement of funds, procurement, monitoring and evaluation. The fact that the funding GHPs have been able to find ways to participate in SWAps with pooled funding in some countries – for example, the GFATM in Mozambique and GAVI in Uganda – suggests that there are challenges but

no insuperable barriers. For their part, countries should be aiming to strengthen systems so that donors are more comfortable relying on them. In the short-term, while such systems are weak, GHP activities should be 'shadow aligning' with countries systems and contributing to building their capacity.

**g. Avoiding parallel Project Implementation Units**  
Implementation conducted vertically through Project Management Units (PMUs) may allow greater focus and increase the individual programme's potential for success, but it can also fragment implementation efforts within a disease area, create parallel structures and consume scarce resources.

For example, a 2004 study in Uganda found that a separate Global Fund Project Management Unit ('the Ugandan Global Fund for AIDS, TB and Malaria') had been established with 20 staff<sup>7</sup>. Instead of adopting a more integrated approach and making use of existing MoH resources and structures, it required the MoH national disease programmes at both national and district levels to submit separate workplans from their own MoH workplans, and established its own procurement facility and a parallel transport system. The study noted a lack of clarity about links between the PMU and the CCM, and between the PMU and the MoH decision-making and monitoring bodies under Uganda's health SWAp.

**h. Predictability (and sustainability) of aid**  
GHPs are delivering large-scale new financing for communicable diseases and other global public goods, against a backdrop of strong growth in development assistance for health over the last three decades<sup>8</sup>. However, in 2004 GHPs had not achieved their aim of attracting new funding sources with the exception of Foundations, especially the Gates Foundation. Most funds continued to be provided by traditional donors, who were then providing

97% of pledges for the GFATM. There were and remain concerns about the uncertainty of future levels of funding for the GFATM, and hence for the disease areas it supports<sup>9</sup>.

Uncertainty in disbursement leads to difficulty in short and medium-term planning. In some cases (e.g. Ghana) where Government identified GHP-funded proposals as part of its national strategies, distortions were created when GFATM applications were not approved<sup>10</sup>.

Tackling the challenges of controlling major diseases requires sustained long-term financing to support sustained, long-term action. In a demonstration project in Zambia, the Gates/PATH Malaria Control and Evaluation Partnership in Africa (MACEPA) programme, funding has been committed for nine years. But replicating this model would be challenging on a number of fronts, not least that it requires longer-term commitments than are typically made today.

If GHPs were to move towards direct budget support, the trade offs in terms of measuring additionality and impact of GHP money would need to be recognized. The general move from sector-based aid to direct budget support raises issues about ensuring that governments allocate sufficient resources to health in their expenditure frameworks, and the skills needed in Ministries of Health to prepare scaled-up budgets and negotiate with Ministries of Finance.

Sustainability is a recurring concern in studies. GHPs have had a prominent role in introducing high value goods (eg antiretrovirals) into under-resourced health systems. Most interventions funded by GHPs are potentially highly cost-effective – except antiretrovirals where there are social justice arguments. Even so, low-income countries are unlikely to be able to meet ongoing costs themselves. This has major implications for sustainability of health sector expenditure. For example, in several countries external funding for HIV/AIDS (most of which has been provided by GHPs) is already equivalent to or greater than the public health budget. (This issue is dealt with in greater detail in another paper prepared for the High-Level Forum: Fiscal space and sustainability from the perspective of the health sector.)

Planning for financial sustainability is often seen as difficult to achieve and not taken seriously. Countries perceive that the magnitude of funding is too large to plan for a handover. For example, in Vietnam, the Ministry of Health supports just 10% of the HIV/AIDS budget in 2005. By 2010, there is

a forecast funding gap for HIV/AIDS of at least US\$ 56 million compared to 2006 peak levels as funding from global health initiatives, partnerships and other donors tapers off.

### i. Managing for results

There is need for common reporting on country results as defined in overall national plans rather than the results attributable to a particular GHP programme. This might be an indicator of progress in relation to good practice. Some GHPs do use only existing national metrics systems, and in the case of GAVI have provided additional resources to improve their quality and audit<sup>11</sup>. GFATM and PEPFAR have agreed on joint reporting.

The McKinsey study found that surveillance metrics for GHP-funded programmes are collected in a fragmented manner and not consistently integrated into national systems. In Zambia, two of the four Principal Recipients of GFATM funding are NGOs who do not currently share the metrics they collect for GFATM programmes, since they are not required to do so. This undermines national planning efforts.

Programmatic monitoring and reporting take significant amounts of valuable time from district and health facility staff. Major variations in reporting indicators and formats (eg in Angola, between the country Health Management Information System (HMIS), the WHO/UNICEF Joint Reporting Form (JRF) and the GAVI report) make the system very cumbersome. In some cases the frequency and timing of GHP reports may also be misaligned, creating additional burdens. For example, in Viet Nam all national health/donor reporting is aligned with Ministry of Health quarterly and biannual reporting, except for GFATM quarterly financial and activity reporting on a TB grant. The latter's financial report is off cycle by just one month, resulting in the need to recompile all the quarterly financials rather than use existing data.

Most countries do not feel sufficiently empowered to ask GHPs to tailor their approach. For example, Ghana changed its SWAp to accommodate the GFATM without asking the Fund about flexibility. This is part of the picture of weak – and on the part of GHPs, unresponsive – communications between GHPs, partners and countries. An unfortunate side-effect is the propagation of myths about GFATM intentions and policies.

Funding GHPs like GAVI and the Global Fund have adopted principles of performance-based

funding or disbursement. Stronger information and accountability systems are needed to inform judgements in relation to performance-based funding. Tying funding to performance creates greater incentive to deliver outcomes and increases accountability of some programmes. There is, however, an issue as to how to balance this with the need for more predictable funding, especially given concerns specific to the health sector. If long-term treatment programmes are started with short-term funding, or if such programmes are “switched off” because performance is judged to be poor, there are ethical and public health implications (for example, drug resistance).

When a country’s Health Management Information System (HMIS) is strong, GHPs should use it. When it is weak, they should invest to improve it rather than develop parallel systems. There should be investment in training of country level staff to improve analytical capability, and ability to make decisions based on data, which would in turn increase the sense of ownership of the data. Helping countries improve their health information systems and use their data will be a key task of the Health Metrics Network.

## j. Accountability

At present the accountability of a GHP is generally judged in relation to its own objectives. Judging its impact on overall health sector and PRS objectives is also required.

Several GHPs already make considerable amounts of information available on their websites. As a matter of principle, in order to ensure public accountability, all GHPs should publish key documents on the internet: annual plans, budgets and performance reports (including income and expenditure reports); evaluations; standing orders, including processes for appointments of Board members and Chairs; and papers and reports of key meetings, especially Board meetings. Funding GHPs should provide timely, clear and comprehensive information on GHP assistance, processes, and decisions (especially decisions on unsuccessful applications) to partner countries requiring GHP support.

This paper addresses itself to best practice principles for GHPs but, as with the Paris Declaration, the logic would be that success would require mutual accountability, with complementary commitments from countries and other partners.

## k. Conclusions

Country studies have for some time now consistently concluded that the undoubted benefits of GHPs are accompanied by high transaction costs – costs that are the direct result of interventions by at least the major GHPs, especially those concerned with funding. The growing human resource gap in some countries implies that they can even less afford the transaction costs imposed by GHPs.

At global level, there is a marked acceleration in action to address some key problems and challenges directly caused by GHPs. For example, various activities are being taken forward urgently as a result of the Global Task Team report, including:

- The GFATM and the World Bank intending to work together to review and improve their alignment with national cycles and action plans; undertake joint annual reviews as primary evaluation where their Principal Recipient of funding is the same (in at least three countries by June 2006); pilot joint fiduciary assessments; foster communications, information-sharing and joint action, for example by regular meetings and sharing reports, terms of reference and mission reports; identify procurement and supply bottlenecks in the implementation of grants; define problems between National AIDS Commissions and CCMs.
- Establishment of a joint UN System/Global Fund problem-solving team and national task-specific problem-solving teams.

Other actions are underway:

- GAVI in its second phase will base support on country's multi-year plans (immunization and health sector plans). Long-term (5-10 year) predictable funding will be a legal requirement in the case of the IFFim, and is likely to provide greater security for governments than current bilateral donor financing which studies have shown to be surprisingly volatile. Coordination mechanisms other than for technical matters (ICC) will fold into sectoral or programmatic processes.
- The Stop TB Partnership is working closely with the GFATM.
- The last few months have seen the launch of the Health Metric Network, action to create a Health Workforce Alliance, and broader WHO-led collaboration – involving GAVI, the GFATM and Stop TB among others – on health systems

strengthening issues (including a sub-group on the non-state sector).

One crucial importance of the McKinsey study is its demonstration that the problems associated with GHPs still figure very large at country level, despite the perception at global level of shifts of attitudes, increased flexibility and progress having been made towards alignment and harmonisation. A possible reason for the gap between global level expressions of support to the principles of alignment and harmonisation and the country findings may simply be the time-lag. Most of the global progress described has been made within the last few months.

Against this background, a key message for GHPs is the importance for them to act with speed and flexibility:

- to endorse and enact some best practice principles for GHPs, primarily relating to alignment and harmonisation; and
- to work with countries, and with other agencies and GHPs, rapidly to get in place solutions to the simpler problems raised, while at the same time developing approaches to the more challenging problems.

#### 4. Proposals for Best Practice Principles for GHP activities at country level

##### a. Draft proposals for best practice principles

The Paris Declaration on Aid Effectiveness is directly relevant to the health sector, and application of its commitments should improve the effectiveness of health development assistance. While there is need to keep GHPs free of unhelpful bureaucracy, they too should honour its commitments since they are now a key part of the global health architecture<sup>12</sup>. The Paris Declaration generally offers an appropriate framework for developing best practice principles for GHP activity at country level, though it notably did not cover technical assistance which is an important issue in relation to the success of GHP support for countries.

The table below therefore sets out draft proposals for best practice principles for global health partnerships and initiatives which are active at country level. These are intended not as an end in themselves but as a means to improve health outcomes and accelerate progress towards achieving the health and poverty reduction MDGs.

The principles will need to be interpreted in light of the specific circumstances of each GHP and

each partner country. The evidence suggests that most of the principles are already practicable for some GHPs, but no single GHP appears to practise all. If the principles are agreed, GHPs may wish to review policies and practices, and prepare an action plan for operationalization.

##### b. Implications of draft Best Practice Principles

###### i. Implications for GHPs

The intention is to move forward swiftly to practical action. Further work in collaboration with individual GHPs is required to explore fully the implications for GHPs of operationalising the best practice principles, which are likely to be different for each GHP.

The following points may serve as useful examples of the kinds of issues that are likely to emerge:

- GHPs should not normally be active in countries where the target disease or condition is not an identified priority in country-owned and -led strategies such as the poverty reduction strategy (PRS) and/or health sector plan. However, there are cases where these plans do not adequately reflect health or prioritize health issues. In such cases, GHPs (like other development partners) have a role in supporting countries to ensure that health is appropriately reflected in PRSs, Sector plans, MTEFs and budgets;
- GHPs without a country presence should consider reaching explicit agreement, possibly backed by formal MOUs, with partner agencies able to represent them in-country, in order to address some current problems about communication and speed of response issues. It may be helpful to extend any such agreement to providing support for implementation;
- Disbursement of funds should be aligned to the government budget cycle, and resources pledged 5 years in advance in order to support health sector planning;
- The implications for fiscal space and fiscal sustainability of introducing (expensive) new technologies should be discussed with ministries of health, finance and planning, and with development partners;
- GHPs should be represented at regular health sector partners' meetings, either directly or through representatives;
- Sustainability planning (for a realistic timeframe) should be coordinated across GHPs, based on a unified discussion with ministries of health, finance, planning and any other relevant national bodies;



## Draft Best Practice Principles for Engagement of Global Health Partnerships at Country Level

Global Health Partnerships (GHPs) commit themselves to the following best practice principles:

Ownership	
1	To respect partner country leadership and help strengthen their capacity to exercise it. GHPs will contribute, as relevant, with donor partners to supporting countries fulfill their commitment to develop and implement national development strategies through broad consultative processes; translate these strategies into prioritised results-oriented operational programmes as expressed in medium-term expenditure frameworks and annual budgets; and take the lead in coordinating aid at all levels in conjunction with other development resources in dialogue with donors and encouraging the participation of civil society and the private sector.
Alignment	
2	To base their support on partner countries' national development and health sector strategies and plans, institutions and procedures. Where these strategies do not adequately reflect pressing health priorities, to work with all partners to ensure their inclusion.
3	To progressively shift from project to programme financing.
4	To use country systems to the maximum extent possible. Where use of country systems is not feasible, to establish safeguards and measures in ways that strengthen rather than undermine country systems and procedures. Country systems in this context would include mechanisms such as sector-wide approaches, and national planning, budgeting, procurement and monitoring and evaluation systems.
5	To avoid, to the maximum extent possible, creating dedicated structures for day-to-day management and implementation of GHP projects and programmes (eg Project Management Units)
6	To align analytic, technical and financial support with partners' capacity development objectives and strategies; make effective use of existing capacities; and harmonise support for capacity development accordingly.
7	To provide reliable indicative commitments of funding support over a multi-year framework and disburse funding in a timely and predictable fashion according to agreed schedules.
8	To rely to the maximum extent possible on transparent partner government budget and accounting mechanisms.
9	To progressively rely on country systems for procurement when the country has implemented mutually agreed standards and processes; and to adopt harmonized approaches when national systems do not meet agreed levels of performance <sup>13</sup> . To ensure that donations of pharmaceutical products are fully in line with WHO Guidelines for Drug Donations <sup>14</sup> .
Harmonisation	
10	To implement, where feasible, simplified and common arrangements at country level for planning, funding, disbursement, monitoring, evaluating and reporting to government on GHP activities and resource flows.
11	To work together with other GHPs and donor agencies in the health sector to reduce the number of separate, duplicative missions to the field and diagnostic reviews assessing country systems and procedures. To encourage shared analytical work, technical support and lessons learned; and to promote joint training, (eg common induction of new Board members).
12	To adopt harmonized performance assessment frameworks for country systems.
13	To collaborate at global level with other GHPs, donors and country representatives to develop and implement collective approaches to cross-cutting challenges, particularly in relation to strengthening health systems including human resource management.
Managing for results	
14	To link country programming and resources to results and align them with effective country performance assessment frameworks, refraining from requesting the introduction of performance indicators that are not consistent with partners' national development strategies.
15	To work with countries to rely, as far as possible, on countries' results-oriented reporting and monitoring frameworks.
16	To work with countries in a participatory way to strengthen country capacities and demand for results-based management, including joint problem-solving and innovation, based on monitoring and evaluation.
Accountability	
17	To ensure timely, clear and comprehensive information on GHP assistance, processes, and decisions (especially decisions on unsuccessful applications) to partner countries requiring GHP support.



## Governance

The governance principles are intended for larger partnerships with formalized governance arrangements. Partnership activities must be consistent with the regulatory framework of their host arrangements.

18	To make clear and public the allocation of roles and responsibilities within the management structure of the partnership or fund. The governing board or steering committee should have broad representation and a strong developing country voice.
19	To make clear and public the respective roles of the partnership and relevant multilateral agencies, including how the partnership relates to the host organization.
20	In the interest of public accountability, to ensure that GHP purpose, goals and objectives are clear; procedures are transparent; and timely and comprehensive information is provided publicly.
21	There should be a strong commitment to minimizing overhead costs and achieving value for money; each partnership should have an evaluation framework.
22	To be subject to regular external audit. For hosted partnerships, the auditing procedures of the host UN organization would apply. A copy of the relevant portion of the external auditors' certification of accounts and audit report should be made available to the partnership board.

- Individual GHPs may need to adapt the indicators used to monitor progress at country level, in line with the development of national health information systems;
- Wherever possible, GHPs should use existing robust analytical work and appraisals of management systems, for example relating to procurement;
- GHPs should allow countries to experiment with the organisation of coordinating bodies to increase efficiency and participation (and countries should ensure appropriate leadership of such bodies);
- GHPs should provide guidance which clearly states that technical assistance for implementation can be an explicit part of proposals;
- GHPs should regularly review their work at country level to see which elements could be handed over to government (eg procurement), and develop where appropriate a plan for disengagement (as in the case of some GHPs working to eliminate specific tropical diseases);
- GHPs and countries should review the need for specific Project Management Units, with a view to disbandment;
- Greater GHP flexibility and tailoring processes to individual country needs will be helpful, but may also make the ground rules less clear for countries and potentially for GHP partners. GHPs will need to invest in communicating proactively the scope and boundaries of flexibility. They could also usefully institute some basic service norms for day-to-day communication (eg a 3-day turnaround time to respond to communications and 30 days to resolve issues).

## ii. Enabling conditions

The corollary to these best practice principles for GHPs would be some complementary commitments on the part of countries and other partners to assist in providing the enabling conditions.

For countries, commitments would include as a minimum to:

- develop clear national health sector strategies, with a medium-term expenditure framework and a health sector plan, within the framework of a broader national development strategy such as a poverty reduction strategy.
- exercise leadership in coordinating partner actions
- have procurement and public financial management systems that either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.

Bilateral and multilateral partners have both joint and differentiated responsibilities in contributing to the enabling conditions. These include:

- Supporting countries to ensure that health is appropriately reflected in PRSs, sector plans, MTEFs and budgets;
- Adopting a coherent position to individual GHPs in their various roles as funders, GHP partners/ Board members, and when operating at country level. They should produce clear guidance for field staff, to be widely-publicised within their organisations, about their role in, and important contribution to, GHPs. Engaging substantively in GHPs will have implications for how staff time and effort is spent;
- Seeking to ensure that no new GHP is established unless the value it adds is demonstrably

clear, and that continued support is dependent on continued need;

- Providing increased and urgent support for technical assistance for implementation. Multi-lateral agencies are themselves likely to require additional support from donors in this area. Further work is required to explore different models for more demand-driven technical assistance. This should consider issues including: agreement on the need; identification of possible sources (local, regional, international); establishing quality standards; agreeing on actual costs; and determining selection procedures.
- Specific consideration should be given to providing organisational, facilitative or administrative support to Country Coordination Mechanisms (CCMs) to allow them to fulfill their oversight functions adequately.
- Working with GHPs to enable them to put some of the principles into effect, eg being subject to external audit when housed by a UN body.
- As a matter of urgency, developing technical guidance on health systems, including work on human resources and health financing mechanisms, to guide GHPs in their work on health systems strengthening. This could include work by countries, GHPs and other partners to evaluate alternative models to fund health systems strengthening instead of individual GHP efforts. Current parallel streams of work on this topic should be brought together.

### *iii. Future follow up of progress*

Given the need to tailor approaches to different settings, these principles are primarily to be operationalised at country level, and in that context, countries may wish to set their own targets and indicators. There is scope for the development of

country-level mechanisms to support compliance through country-specific agreements between all partners on rules of engagement.

A practical example of the kind of agreement envisaged is provided by the Memorandum of Understanding between the Government of Uganda and its development partners, in support of the National Health Policy and the second Health Sector Strategic Plan 2005-2010, through a sector-wide approach. It sets out the obligations of all parties (for example, for partners to use Government systems including the Health Management Information System; synchronise planning, review and monitoring processes with those established to monitor the Health Sector Strategic Plan; and negotiate with the Ministry of Health all new health/health service programmes to be implemented in districts). It also details approaches, eg to procurement and to the provision of technical assistance (which is to be determined on a demand-driven basis, and encourage the use of Ugandan or regional consultants for short-term assistance).

The HLF Working Group on GHPs feels that no additional global mechanism for coordination or monitoring is required or appropriate. A preferable alternative would be for a light-touch and issue-focussed forum to be held on a regular basis. Its purpose should be to provide an opportunity for key players from major GHPs, recipient governments and donors to review principles, practice and progress; and address issues of joint concern, including overlaps, gaps and systems issues. Ideally such a discussion would take place within the wider context of taking stock of developments in the health sector as a whole and should be supplemented by more informal liaison and information-sharing between the 5-6 large GHPs on a regular basis.

## Annex I

### The Paris Declaration of Aid Effectiveness: indicators of progress and targets

#### To be measured nationally and monitored internationally

Indicators		Targets for 2010	
Ownership			
I	Partners have operational development strategies	At least 75% of partner countries have operational development strategies.	
Alignment			
2a	Reliable public financial management (PFM) systems	Half of partner countries move up at least one measure (i.e., 0.5 points) on the PFM/ CPIA (Country Policy and Institutional Assessment) scale of performance.	
2b	Reliable procurement systems	One-third of partner countries move up at least one measure (i.e., from D to C, C to B or B to A) on the four-point scale used to assess performance for this indicator.	
3	Aid flows are aligned on national priorities	Halve the gap – halve the proportion of aid flows to government sector not reported on government's budget(s) (with at least 85% reported on budget).	
4	Strengthen capacity by co-ordinated support	50% of technical co-operation flows are implemented through co-ordinated programmes consistent with national development strategies.	
5a	Use of country public financial management systems	For partner countries with a score of 5 or above on the PFM/CPIA scale of performance (see Indicator 2a).	All donors use partner countries' PFM systems; and Reduce the gap by two-thirds – A two-thirds reduction in the % of aid to the public sector not using partner countries' PFM systems.
		For partner countries with a score between 3.5 and 4.5 on the PFM/CPIA scale of performance (see Indicator 2a).	90% of donors use partner countries' PFM systems; and Reduce the gap by one-third – A one- third reduction in the % of aid to the public sector not using partner countries' PFM systems.
5b	Use of country procurement systems	For partner countries with a score of 'A ' on the Procurement scale of performance (see Indicator 2b).	All donors use partner countries' procurement systems; and Reduce the gap by two-thirds – A two-thirds reduction in the % of aid to the public sector not using partner countries' procurement systems.
		For partner countries with a score of 'B' on the Procurement scale of performance (see Indicator 2b).	90% of donors use partner countries' procurement systems; and Reduce the gap by one-third – A one- third reduction in the % of aid to the public sector not using partner countries' procurement systems.
6	Avoiding parallel implementation structures	Reduce by two-thirds the stock of parallel project implementation units (PIUs).	
7	Aid is more predictable	Halve the gap – halve the proportion of aid not disbursed within the fiscal year for which it was scheduled.	
8	Aid is untied	Continued progress over time.	
Harmonisation			
9	Use of common arrangements or procedures	66% of aid flows are provided in the context of programme-based approaches.	
10a	Missions to the field	40% of donor missions to the field are joint.	
10b	Country analytic work	66% of country analytic work is joint.	
Managing for results			
11	Results-oriented frameworks	Reduce the gap by one -third – Reduce the proportion of countries without transparent and monitorable performance assessment frameworks by one-third.	
Mutual accountability			
12	Mutual accountability	All partner countries have mutual assessment reviews in place.	

## Notes on the Paris Declaration:

1. The targets, in accordance with the Paris Declaration, are: “designed to track and encourage progress at the global level among the countries and agencies that have agreed to this Declaration. They are not intended to prejudge or substitute for any targets that individual partner countries may wish to set.” They are subject only to reservations by one donor on (a) the methodology for assessing the quality of locally-managed procurement systems and (b) the quality of public financial management reform programmes.

2. The universe for the purpose of targeting is limited to ODA eligible countries that have already endorsed the Paris Declaration or will have endorsed it by 31 December 2005. The universe for the purpose of monitoring is open to all ODA eligible countries that have already endorsed, or will endorse in the future, the Paris Declaration.

3. **Note on Indicator 9** – Programme based approaches are defined as a way of engaging in development cooperation based on the principles of co-ordinated support for a locally owned programme of development, such as a national development strategy, a sector programme, a thematic programme or a programme of a specific organisation. Programme-based approaches share the following features:

- (a) leadership by the host country or organisation;
- (b) a single comprehensive programme and budget framework;
- (c) a formalised process for donor co-ordination and harmonisation of donor procedures for reporting, budgeting, financial management and procurement;
- (d) efforts to increase the use of local systems for programme design and implementation, financial management, monitoring and evaluation.

For the purpose of indicator 9, performance will be measured separately across the aid modalities that contribute to programme-based approaches.







# 4

# MONITORING THE HEALTH MDGs

By Health Metrics Network, Geneva, January 2004



## 1. Introduction

Health information is the foundation of public health. The “evidence-based” medicine revolution of the last 30 years has had some spill-over into public health, as the disciplines of epidemiology, demography and economics have gained prominence. Yet many health systems remain woefully inadequate on critical health information fronts.

We still cannot count the dead in the vast majority of the world’s poorest countries – paradoxically these are countries where the disease burden is greatest. In sub-Saharan Africa fewer than ten countries have vital registration systems that produce usable data. We still have very limited measures of health systems performance. The considerable investments in measuring health outcomes, often to monitor the effectiveness of donor-driven programs or address emergencies such as the AIDS epidemic, too often do not add to or strengthen national health information systems. Little investment has been made to date in a definitive solution to meeting the demand for better health information – by strengthening systems that meet the local and national, as well global, needs for evidence to inform decision making.

Monitoring of policies and actions, and building country capacity in health information systems, are two initiatives for addressing the gap between the demand for health information and the information available. There are, however, many unresolved issues:

- What needs to be done to change the behaviour of donors and countries to better respond to local, national and global information needs? How can the *Health Metrics Network* contribute most effectively to improving the availability and use of sound health information?
- Which specific government *policies* are most important for monitoring, and what are the best ways to collect the information?
- What specific leading indicators should be monitored as *determinants* of long-term goals?

What indicators and which kinds of packaging of information are most appropriate to raise awareness and mobilize resources from constituencies beyond health?

## 2. Increased demand for better monitoring of results in health

The Millennium Development Goals, adopted unanimously by the members of the United Nations in 2000, set specific targets for improving income poverty, education, the status of women, health, the environment, and global development cooperation. Now widely accepted as a framework for measuring development progress, the goals focus the efforts of the world community on achieving significant, measurable improvements in people’s lives. They establish yardsticks for measuring results – not just for developing countries, but also for high income countries that help to fund development agencies and for the multilateral institutions that help countries implement these programs.

Health is prominently represented in the MDGs, with four of the goals calling for monitoring of progress towards improving the health and survival of mothers and children, and reduced prevalence and mortality from leading communicable diseases. The health MDGs represent long-term goals, to be achieved over a 25 year period. Annual changes in the outcomes will necessarily be small, and will be difficult to monitor given the weakness of current health information systems. At present, donors, international agencies, and countries can expect only occasional, incomplete, and usually imprecise snapshots of country progress towards the goals, with much of the progress assessment heavily dependent on modelling rather than on empirical evidence.

Increasingly, international assistance in health is linked to effective use of available resources. Performance-based monitoring involves reporting on intended results and progress towards achieving them. It requires that clear, achievable objectives that are within the control of a program or ministry,

are set and agreed on by all stakeholders, with sufficient resources available to deliver the results. It also requires the selection of indicators to monitor performance, and an agreed plan for when, how and by whom the indicators will be generated and used. Performance-based monitoring cannot be based on outcome or impact indicators because of the long-term nature of such changes and the measurement challenges.

Performance-based monitoring can only be achieved if programs routinely and accurately track policies, inputs, actions, and outputs related to the interventions. This inevitably entails increasing resources devoted to monitoring.

The importance of health outcomes in the MDGs, and the increasing attention paid to performance, have created a growing demand for high quality health information. Linking performance with donor assistance will require that country health information systems are able to use standardized definitions of health indicators and to ensure the consistent application of methodologies. There is currently, however, a remarkable disconnect between the demand for high quality health information and the ability of country systems to respond to the demand. To address this challenge, two initiatives to improve the availability, quality and use of health information are under way.

- Monitoring of the policies and actions of developing and developed countries for achieving the MDGs is a key element of an overall monitoring framework. The **Global Monitoring** report to the Development Committee is planned as an annual update of trends in policies and actions that contribute to development outcomes, including health. As part of this, monitoring and projection of trends in leading indicators needs to be expanded beyond the list of indicators included in the current MDG framework, to include availability, access and utilization rates of interventions for which there is widespread agreement about their effectiveness;
- To improve the capacity of countries in the area of health statistics, an alliance of countries and international partners has been formed. The **Health Metrics Network** aims to bring together countries, donors and international agencies to pool resources and address the paucity of information collectively. With the assistance of the Network, countries will develop national plans for improving health information, mobilize resources from partners, invest in health infor-

mation systems, build national capacity and improve the utilization of health information.

### 3. Building health information systems: the Health Metrics Network

The increased demand for health information calls for an investment in building sustainable country health information systems. A health information system refers to the integrated effort to collect, process, and report health information to influence policy making, interventions, and research. Health information systems include several subsystems:

- disease and risk factor surveillance and outbreak notification
- population and facility-based surveys
- registration of vital events, including causes of death
- data collected from patient and service records
- administrative data on budget, human resources, supplies, etc.
- modelling and estimates.

Improvement in health information systems is needed at local, national and international levels, and more integration between these levels is required to deal with global health threats, such as the AIDS epidemic, and to make the best use of the growth of knowledge in health. Innovative approaches are now becoming available that will permit better measurement of health status through technology development, better recording of vital events, through sentinel sites, and better data availability at sub-national levels through a district data initiative; these and other innovations have the potential to improve the information situation rapidly if applied in coherent ways by all stakeholders.

Reforms of health information systems need to be based on a national plan with a policy framework, core indicators, and data collection, analysis and dissemination strategies. Such nationally developed strategic plans should be specific about how the different tools and methods will be applied and complement each other, how health information needs are met at the sub-national, national and global levels, and what kind of investments are needed. The latter include human resources, infrastructure (technology, laboratories, etc.), and operational budgets for health data collection efforts. National bodies with participation of stakeholders of different levels of users and technical experts need to guide and oversee the implementation of

the national plans. International investors in health information should buy into and support the country strategies.

In July 2003, a group of national and global health and development partners – countries, international agencies, bilateral and multilateral donors, foundations and technical experts – came together and agreed on a simple proposition: meeting the health challenges of the 21<sup>st</sup> century requires much better health information than is currently available. In response, the Health Metrics Network (HMN) was established that involves a wide range of stakeholders in health information. The HMN is based on the premise that the complexity of the health information field – multiple actors, types, sources, users and uses of information – requires a collaborative and inclusive response. A partnership or network permits the involvement of different actors according to their needs and capacities, at the same time providing overall coherence and links across levels and among partners. (See Annex A for update on activities.)

#### 4. Monitoring of policies and actions for achieving the MDGs

At its April 2003 meeting, the Development Committee reaffirmed its commitment to regular monitoring of the policies and actions of developing and developed countries and development agencies for achieving the Millennium Development Goals and related outcomes. For developing countries, it highlighted three key areas for attention:

- strengthening the rule of law and infrastructure to improve the environment for private sector activity;
- improving the quality of governance and strengthening capacity in the public sector; and
- increasing the effectiveness of the delivery of human development and related services to poor people.

For developed countries, the paper emphasized two priority areas for action: increased market access for developing country exports, including the reduction of domestic subsidies in agriculture, and more and better aid, including adequate support for global programs on education, HIV/AIDS, and water, and implementation of harmonized and related good-practice approaches to development assistance.

Monitoring of government policies and actions will require timely and robust indicators. And while full objectivity will be unlikely to be achieved, a high degree of transparency in how policies and

actions are assessed, is essential. Efforts to strengthen the World Bank's Country Policy and Institutional Assessment (CPIA) methodology and its application, including the use of more transparent indicators and more extensive discussion of country ratings with governments, are already underway. Increased robustness, transparency, and disclosure of the CPIA ratings would enhance the usefulness of these key policy metrics for global monitoring carried out by the World Bank and its partners.

With good policies and institutions, increasing the share of GDP devoted to health could make a difference between making enough progress to meet the MDGs and missing the targets. But aggregate public health expenditure indicators by themselves provide little information regarding the particular expenditure patterns, such as geographic allocation, specific targeting and specific public expenditure management practices that are important for such expenditures to have an impact on outcomes. A priority for improving monitoring of policies related to health spending consists of implementing national health accounts (NHA), as an important tool for assessing the adequacy and quality of health expenditures, including their overall level, composition, and management. NHA will also identify the sources of financial flows, including from central governments to sub-national units, and from donors to recipient countries. When fully implemented, NHA will enable policy-relevant tabulations of the distribution of health expenditures among population sub-groups and by intervention. New tools are available to assist countries to implement and sustain NHA.

More efforts are needed to develop an agreed set of reliable and transparent indicators of the performance of health systems. While the CPIA includes an assessment of overall public sector management and institutions, as well as policies for social inclusion and equity (including some information on access to and quality of health services), there is a need to develop additional health-sector specific governance indicators. Such indicators would provide information on how efficiently health systems use resources to improve health, identify key constraints to improved performance, and how equitable systems operate.

#### 5. Monitoring intermediate indicators

Measurement of health indicators has improved substantially over the past decade; many countries have conducted health and demographic household surveys and surveillance of HIV/AIDS through



antenatal testing is carried out in virtually all severely affected countries. Compared with 1990, there are now significantly more countries for which we can more confidently report on levels and trends in childhood mortality or malnutrition. By contrast, in other areas, such as maternal and reproductive health or surveillance of most communicable diseases, data are much less available and frequently of poor quality. Overall, a much greater international effort is needed to address the monitoring and evaluation challenges presented by the MDGs, Poverty Reduction Strategy Papers, or the Global Fund against AIDS, TB and Malaria. Sound health information is not only needed to report on these international initiatives, but is essential for sound

program development and implementation as well. But international initiatives, such as the MDGs and programs targeting specific diseases, tend to focus on data for disease-specific indicators and do not necessarily translate into building information systems that meet country and international needs in both the short and long run. All too frequently, the demand for health information is accompanied by the implementation of population-based surveys which bring major benefits in terms of data but remain resource intensive, have long intervals between surveys, and are not appropriate for supplying all information needs which may be better met using other approaches such as vital registers or routine service statistics. Moreover, surveys often

**Table 1 Effective interventions for reducing illness, deaths and malnutrition**

MDG indicator	Preventive interventions	Treatment interventions
Child mortality	Breastfeeding. Hand-washing, safe disposal of stool, latrine use and safe preparation of weaning foods. Use of insecticide-treated nets. Complementary feeding. <u>Immunization</u> . Micronutrient supplementation (zinc and vitamin A). Antenatal care, including steroids & tetanus toxoid. Antimalarial intermittent preventive treatment in pregnancy. Newborn temperature management; Nevirapine and replacement feeding; Antibiotics for premature rupture of membranes; Clean and safe delivery including management of pregnancy-related complications such as eclampsia and obstructed labour.	Case management with: <u>Oral rehydration therapy for diarrhoea</u> ; <u>antibiotics for pneumonia</u> , dysentery and sepsis; and, antimalarials for malaria. Newborn resuscitation and management of hypothermia. Breastfeeding, complementary feeding during illness, and micronutrient supplementation (zinc and vitamin A).
Maternal mortality	Family planning; <u>contraceptives</u> . Maternal nutrition and micronutrient supplementation. Prevention and treatment of STI and HIV. <u>Prevention and treatment of malaria and other infections</u> . <u>Antenatal care</u> .	<u>Safe delivery with skilled birth attendance</u> ; Essential/Emergency obstetric care; Post partum and post abortion care.
Nutrition	<u>Exclusive breastfeeding</u> -6 months. Appropriate complementary child feeding 6-24 months. Iron and folic acid supplementation of children. Improved hygiene and sanitation. Dietary intake- pregnant and lactating women. <u>Micronutrient supplementation for prevention of vitamin A deficiency</u> and anaemia in mothers and children. Anthelmintic treatment in school aged children	Appropriate feeding of sick child and ORT. Control and timely treatment of infectious and parasitic diseases. Treatment and monitoring of severely malnourished children. High dose treatment of clinical signs of vitamin A deficiency
HIV/AIDS	<u>Safe sex, including condom use</u> Unused needles by drug users, <u>Treatment of STIs</u> . Safe, screened blood supplies. Universal precautions including safe injections. <u>Anti-retrovirals in pregnancy</u> to prevent maternal to child transmission and after occupational exposure.	Treatment of opportunistic infections. Cotrimoxazole prophylaxis. Highly active anti-retroviral therapy. Palliative care.
TB	Directly observed treatment of infectious cases to prevent transmission and emergence of drug resistant strains & treatment of contacts. BCG immunization.	<u>Directly observed treatment to cure, including early identification of TB symptomatic cases</u> .
Malaria	<u>Use of insecticide-treated nets</u> . Indoor residual spraying (in epidemic-prone areas). <u>Intermittent presumptive treatment of pregnant women</u> .	<u>Rapid detection and early treatment of uncomplicated cases</u> . Treatment of complicated cases (e.g., cerebral malaria and severe anaemia).

NB: The underlined interventions have corresponding indicators for use in the monitoring of MDGs

**Table 2 Examples of intermediate or proxy indicators**

Millennium Development Health and Nutrition Targets	Recommended options: Examples of intermediate or “proxy” indicators
Target: Halve, between 1990 and 2015 the proportion of people who suffer from hunger	<ul style="list-style-type: none"> <li>• Prevalence of underweight children under five</li> <li>• Proportion of infants under six months who are exclusively breastfed</li> <li>• Proportion of children 6 – 59 months who received one dose of vitamin A in the past six months</li> </ul>
Target: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	<ul style="list-style-type: none"> <li>• Proportion of 1 year old children immunized against measles</li> <li>• Proportion of children with diarrhoea in the past two weeks who received ORT</li> <li>• Proportion of children with fast or difficult breathing in the past two weeks who received an appropriate antibiotic</li> </ul>
Target: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	<ul style="list-style-type: none"> <li>• Percentage of pregnant women with any antenatal care</li> <li>• Percentage of births with skilled birth attendant and/or institutional delivery</li> <li>• Contraceptive prevalence rate</li> </ul>
Target: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS	<ul style="list-style-type: none"> <li>• Percent of persons using a condom at last higher risk sex</li> <li>• Percent of sexually transmitted infection clients who are appropriately diagnosed and treated</li> <li>• Percent of HIV-positive women receiving antiretroviral treatment during pregnancy</li> </ul>
Target: Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases	<ul style="list-style-type: none"> <li>• Percent of patients with uncomplicated malaria who received treatment within 24 hours of onset of symptoms</li> <li>• Percent of children/ pregnant women sleeping under insecticide treated nets</li> <li>• Proportion of women receiving antenatal care who receive at least two or three intermittent preventive malaria treatments during pregnancy</li> <li>• Percent of registered new smear positive TB cases in a cohort that were successfully treated</li> <li>• Percent of estimated new smear positive TB cases that were registered under DOTS approach</li> </ul>

For a complete list of recommended core intermediate and optional indicators, see report *Health, Nutrition, and Population Development Goals. Measuring Progress Using the Poverty Reduction Strategy Framework*, November 2001

produce national level data of limited use for informing program implementation.

Furthermore, the health MDGs are reported as national averages and do not provide information on whether progress has been made in reducing inequity in health within countries. Many countries are unable to report MDGs or other development indicators by key dimensions of equity, such as poverty, gender, geographic residence and ethnicity. Much more needs to be done to incorporate equity measures in health information systems, which should lead to much greater ability to monitor the equity dimension of MDGs.

Strengthening country health information systems will take time, and more accurate and detailed information will not be available in the early stages of the reform. MDG health targets are longer-term

outcomes that can only show minimal improvements on a yearly basis, and can lead to the mistaken conclusion that there is minimal return on investment. The need for timely information to monitor progress on global initiatives requires that additional attention be paid to “upstream” or “leading” indicators of future trends in MDGs and other outcomes. What is needed is a set of easily understandable and verifiable near-term performance metrics that can inspire increased attention and be used as a basis for decisions on resource allocation. Indicators of government policies and actions are by themselves not sufficient to show whether interventions are effectively reaching households that need them.

Intermediate – or proxy - indicators measure changes in coverage or use of interventions known to have an impact on health outcomes. Table 1

shows available preventive and treatment interventions for the health-related MDGs. Such interventions can then be transformed into indicators of coverage and utilization by measuring the number of people who are in need of the intervention, and those who actually receive them. Such indicators include immunization coverage, use of child and maternal health services, and individual or household behaviour. Given the range of health issues that affect countries in different regions and at different stages of the health transition, it is essential that a set of indicators be used to capture such variation. Single indicators, or indices constructed from a set of indicators, cannot be relevant globally, and do not give information on where or how to intervene. At a consultation of development part-

ners at the World Bank in 2001, a first attempt was made to identify a limited set of indicators as the most appropriate proxies for short-term monitoring of the MDGs (Table 2). These proxy indicators are generally more amenable to measurement through regular surveys or routine data collection systems than long-term goals. They are sensitive to change and affected by implementing effective policies, and measures developed for them can show change in the short to medium term. Most importantly, they provide information that is relevant for the management of health programs. The Health Metrics Network can provide a platform to reach consensus around a core set of proxy indicators for tracking progress in relation to key health goals and targets.

## **Annex A**

### **Health Metrics Network: Update on activities, June 2006**

The formal launch of Health Metrics Network (HMN) took place in May 2005 and was accompanied by the first call for proposals from low and middle income countries where the need to improve health information to support decision-making is most acute. The support is mainly catalytic in nature, intended to facilitate the assessment of the current health information system and to enable stakeholder involvement and consensus-building around a long-term national plan.

Since then, a series of inter-country regional workshops has brought together health information and statistical constituencies to encourage the development of a shared diagnosis of health information system strengths and weaknesses and a shared vision for moving forward.

In October 2005, a total of 41 countries were recommended to receive support from HMN.

#### **HMN tools for country support**

In addition to the technical support being provided directly to countries, the HMN Secretariat is developing a series of mechanisms and tools by which countries can access technical support. These include;

- HMN Framework – provides the conceptual and technical framework and standards guiding the strengthening of the country health information systems.
- HMN Assessment Tool – to help countries identify priorities for strategic planning and monitor progress in strengthening health information systems.
- Group Builder – which helps those organizing an assessment to form several groups of informants and divide the assessment items among those groups
- Guidelines for Strategic Planning Tool – to assist with the development of an integrated and strategic HIS strengthening plan, including costing
- Country Log Book – which contains information related to surveys, vital registration, surveillance, routine HIS, and population health research-related activities carried out in countries from 1994 to the present. The database also contains information on censuses carried out over the last 30 years (1974- present).
- SAUCE (Synthesis, Analysis and use of Country Evidence) – designed to enhance appropriate

use of data for resource allocation and to improve the use of existing data to inform major planning cycles within countries. Priorities include the harmonization of tools and methods, enhancing In-country or regional capacity in data analysis, synthesis and use, mapping of currently available tools, development of better methods and tools for data synthesis and analysis on trends, burden of disease and resource allocation and translating of results for specific target audiences

#### **HMN research and development initiatives**

- Health Systems Metrics – In the context of the increasing role of Global Health Partnerships (GHPs) and multi- and bilateral agencies there was agreement on the need to improve monitoring health systems and that a small number of core indicators and associated measurement strategies for health system monitoring should be identified.
- Significant efforts are also focusing on developing a strategy to increase low income countries' capacities to monitor vital events or "count the dead". HMN convened the Monitoring of Vital Events (MoVE) working group whose strategy includes advocacy efforts, coupled with strong technical advances (including data collection in countries and innovative ways of making the best use of incomplete data sets, verbal autopsy tools etc).

#### **HMN collaboration with partners**

The Health Metrics Network is collaborating with partners including UN agencies, donors and GHPs such as the Global Fund and GAVI to help strengthen health system metrics and increase focus on the monitoring and evaluation of grants and support increasing efforts towards harmonization and alignment of development aid in the context of national health systems development.

PARIS21 partners and HMN are currently working together to produce a guide to integrating the needs of sectoral information systems into national statistical capacity building programs.

The HMN Secretariat is involved in MAPS Steering Committee and the HMN Technical Advisory Group (TAG) was invited to participate in MAPS.

HMN has also teamed up with the World Bank International Household Survey and shares the database of existing and planned country household surveys. In addition, the IHSN Microdata Management Toolkit provides free software enabling countries to bring together data from different sources and

generate analyses and reports thereon. HMN is working with IHSN to promote the Toolkit as a key element of a national data repository to which all relevant stakeholders can have access.

### **Advocacy and communications**

The HMN is keeping interested partners informed and increasing partnerships and information sharing through a regular newsletter, website and other web-based tools that enable effective collaboration across organizational and geographic boundaries.

On 30 May 2006, the World Health Assembly (118<sup>th</sup> Session) passed a resolution (EB118.R4) put

forward by HMN and WHO supporting the strengthening of health information systems.

The second call for proposals was announced on 1 June 2006.

For further information on the Health Metrics Network please contact;

Health Metrics Network Secretariat  
World Health Organization  
Avenue Appia 20, 1211 Geneva 27  
Switzerland

Or visit the website <http://www.who.int/healthmetrics/en/>



# TRACKING RESOURCES FOR GLOBAL HEALTH: PROGRESS TOWARD A POLICY RESPONSIVE SYSTEM

By Global Health Resource Tracking Working Group, Abuja, December 2004



## 1. Introduction

In January 2004, at the first meeting of the High-Level Forum on the Health Millennium Development Goals (HLF), the shortcomings in the international community's current ability to monitor resource flows in global health were observed. The need to improve the availability of information on resource flows was identified as a priority for action, and the World Bank and the World Health Organization (WHO), in collaboration with the Organization of Economic Development and Cooperation (OECD), were asked to assess the "feasibility of improving the tracking of financial investments in the health sector at national level, from domestic and external sources, using national health accounts and other financial flows data"<sup>1</sup>.

This paper is a response to that request and is organized as follows: First, it identifies key links between resource tracking and making progress towards meeting the health Millennium Development Goals (MDGs). Second, it lays out the specific ways in which information on resource flows, including data on both commitments and disbursements, can inform policymaking, and indicates the type of information required to each policy use. Third, it highlights major sources of data on resource flows that are currently available, and identifies major gaps relative to policy needs. Fourth, it briefly summarizes the major gaps in the available data, relative to policy needs. Finally, it identifies a set of key issues that need to be addressed to develop an appropriate strategy to fill these gaps.

Much of the work in this area is being undertaken by the "Global Health Resource Tracking Working Group". The Working Group is led by the Global Health Policy Research Network (PRN) of the Center for Global Development (CGD), and benefits from the participation of a wide range of representatives from the official and non-government sectors<sup>2</sup>. Members of the HLF Secretariat from the World Bank and WHO have also been substantively involved in the initiative.

## 2. Resource tracking and the health MDGs

It is widely agreed that accelerating progress towards the achievement of the health-related MDGs will require both a large increase in the financial resources dedicated to the health sector in developing countries, and improved effectiveness in the use of resources. Developing policies that result in more funding and better use of financial resources, in turn, requires a supportive information base – one that provides data about the availability and use of funding in a way that is detailed, timely and credible. A core information base would greatly facilitate efforts in generating and maintaining political will, developing appropriate policies, and holding responsible parties accountable for fulfilling their financial commitments.

## 3. Information for policymaking

At international and country levels, many public and private actors in global health have an interest in knowing how much funding is available and how it is used (see Box 1).

Key decisions – from setting advocacy priorities to designing and monitoring health sector reforms – depend in part on the availability of specific types of information on funding. These are described below:

- **Resource mobilization** – Advocates for more resources for health generally require prospective information about donor and public sector funding commitments and recent budget execution, particularly from donor and lending agencies. Greater predictability in aid flows is required.
- **Resource allocation** – Those responsible for ensuring that health resources are allocated in ways that correspond to priority health programs, including priorities established in Poverty Reduction Strategies, require prospective information about donor and public sector funding commitments and recent budget execution. These stakeholders may include representatives

## Box 1 Potential users of information on resource flows

**Technical Agents** – epidemiologists, policy analysts and economists within the Ministry of Health, national research institutions and international organizations. These users will be interested in access to primary data on resource flows primarily to examine questions of the allocation of resources across program areas.

**Donors** – representatives of UN Agencies and development banks, and key bilateral donors. Donors generally are interested in spending trends by governments and other donor agencies; additionality; and allocation across sectors and programs.

**Public sector administrators in developing countries** – mostly from the Ministry of Health, the Ministry of Finance, the Ministry of Planning and the president's or prime minister's office. Government officials generally look at spending trends; efficiency issues; recurrent costs associated with new investments; and the predictability of funding. Prospective information (commitments) is of special interest.

**Interest groups/advocacy groups** – NGOs providing global health care services and community organizations. These groups usually look at spending trends relative to estimates of resource requirements. They attempt to hold donors and governments accountable to rhetorical commitments.

**Politicians** – (in both developed and developing countries) ministers and deputy ministers, members of Parliament, members of the cabinet, the president and the prime minister. This group is generally concerned with the “big picture” information and comparisons, often inter-regional comparisons and/or spending trends in overall spending. They are often concerned with waste and misuse of funds.

from donor and lending agencies, country-level executive and/or legislative staff, and civil society watchdog organizations.

- **Fiscal planning and donor coordination** – Decision makers seeking to minimize duplication of effort and optimize complementarities need prospective information about donor and public sector funding commitments.
- **Measurement of efficiency and equity** – Analysts and policymakers working to improve the performance of the health sector often seek to understand (a) the relationship between health system inputs and outputs or outcomes; and (b) the distribution of health sector resources by sub-population (e.g., by income quintile). Information is required about recent public and private expenditures by program and geographic area, including expenditures that are financed by donor and lending agencies. Complementary information also is required about health outputs and outcomes, by sub-population.
- **Design of financing strategies** – Analysts and policymakers seeking to design sustainable, fair, health financing strategies also require an equally detailed level of information about recent program expenditure. This will help to prioritize health in national development plans and budgets.

In short, for the purposes of resource mobilization, resource allocation and donor coordination, the highest priority information needs are for donor commitments and disbursements, public sector budgets and disbursements, and private sector expenditures. For the purposes of measurement

of equity and efficiency and design of financing strategies, the highest priority need is for detailed information on public and private expenditures broken down program and geographic area. International comparability across countries, policy-relevant categorization, and inclusion of all sources of funding are essential.

### 4. Current sources of data on financial flows in global health

Several organizations have developed health resource data collection systems to assist in the guidance of policy making and/or advocacy efforts for major donors (bilateral and multilateral) and for recipients of official development assistance. Some of these are listed below.

#### a. Information on bilateral and multilateral institutions' commitments

The Organization for Economic Co-operation and Development's Development Assistance Committee (OECD/DAC) operates the Creditor Reporting System (CRS), an online database that presents the official statistics for the financial flows of official development assistance (ODA) and official aid (OA) of DAC members. CRS, which depends on information reported periodically by members according to an established common format and definitions, provides textual and numerical information on individual transactions. The purpose is to help identify long-term trends in aid flows. The main users of the database are DAC members who can analyze where aid goes, what purpose it serves and

what policies it supports. Policy analysts in both industrialized and developing countries also use the data. Data are available at both the level of individual projects or in aggregate tabular form. In general, data are presented according to the date when the commitment is made, and do not show the allocation of funding over multi-year periods. Data on aid activities financed from multilateral institutions' regular budgets are included in the database to improve the system's capacity for sector and geographical analysis. The financing of specific projects facilitated by multilateral institutions (non-core or extra-budgetary funding) is classified as bilateral.

#### **b. Information on bilateral and multilateral institutions' commitments and disbursements for specific programs**

UNAIDS, UNFPA and the Netherlands Interdisciplinary Demographic Institute have undertaken exercises to measure the funds that are committed and made available for specific disease programs and/or interventions (i.e., HIV/AIDS and reproductive health). The StopTB and Roll Back Malaria partnerships are starting to undertake similar work. The Global Forum on Health Research routinely estimates spending on research and development in health. In general, these initiatives are based on specialized data collection at the global level, with a relatively high degree of detail. However, they are hindered by underlying constraints in donors' and governments' ability to report detailed information.

#### **c. Information on budgetary commitments for health at the country level**

To varying degrees, all governments publish budget information, including allocations to the health sector and actual expenditures. This information is often used as the basis of World Bank Public Expenditure Reviews, some of which have a special focus on the health sector. In general, this information is compiled in budgetary categories such as capital investments, personnel expenditures, and transportation and other recurrent costs, which do not correspond to programmatic categories such as "immunization program," or "HIV/AIDS prevention."

#### **d. Information on retrospective public, private and externally funded expenditures on health at the country level**

One of the tools currently used to collect core information is the National Health Accounts (NHA), an internationally accepted methodology used to

measure a nation's total health expenditure patterns, including public, private, and donor spending. NHA provides health expenditure information on sources and uses of funds, and can also track public budgets in its resource cost matrix. NHA methodology has been applied in a large number of developing countries, but in many cases has been a one-time exercise and is not part of an on-going system of expenditure analysis.

The World Health Organization compiles and reports a five year series on estimated health expenditure for all its member states (currently 192) annually in its World Health Report. This includes estimates of total health expenditures, government health expenditures, expenditures on private pre-paid plans for health and social health insurance, as well as private out-of-pocket spending. Information is also presented on the external resources used in the country for health, derived from the OECD/DAC Creditor Reporting System (see <http://www.who.int/nha/country/en/>).

#### **e. Information on public and private expenditures on specific health programs at the country level**

Special satellite versions of national health accounts have been used to assess expenditures on AIDS. In addition, the Global Alliance on Vaccines and Immunization (GAVI) has undertaken financial sustainability planning work in several dozen countries; the plans include a detailed examination of public (government and donor) expenditures on immunization program-specific activities. These initiatives tend to be one-time efforts, and only in selected countries. They are limited for some policy uses because they present information in programmatic categories, rather than budgetary line items.

#### **f. Information on public expenditures on specific services at the local level**

The World Bank has pioneered Public Expenditure Tracking Surveys, which attempt to track to the micro level the public spending on core services, such as schools and health clinics. These have been used in a few countries.

### **5. Gaps**

Relative to what is needed for many policy and planning purposes, the following gaps can be identified:

- No on-going system provides comprehensive information about donor commitments and disbursements and national government budget

allocations and actual expenditures by programmatic category relevant to the health MDGs. Such information, disaggregated for example into immunization, diarrhoeal disease control, and other categories, would prove valuable for the purposes of resource mobilization, resource allocation and donor coordination. This deficit has led to multiple interest groups conducting or commissioning special studies, which themselves are limited by incomplete information.

- Across many data sources gaps exist in country coverage, comprehensiveness and detail, and timeliness. In addition, data collection often is based on a questionnaire-style approach, which may result in problems with accuracy and consistency across countries and institutions, as well as being an excessive burden on data reporters at agencies and within developing country governments.
- Data on private sector contributions and expenditures, including those from household, corporate and foundation sources, is severely limited.

## 6. Key issues

Several key issues must be addressed in any effort to improve tracking of financial resources in global health. These include:

- *Building on existing budgeting and monitoring systems and analytic frameworks:* To the extent possible, new efforts should build on and strengthen existing systems in a sustainable way, ensuring that they are better articulated with each other.
- *Level of detail, or “granularity”:* There are strong demands to disaggregate information into disease, intervention and other detailed categories. There also are demands for information about expenditures at sub-national levels. It is important to consider whether this could be done using routinely generated information in international agencies and/or governments and whether recent developments in information technology

could facilitate this process. If not, the feasibility, cost and benefit of special exercises would need to be considered.

- *Cost:* There is a never-ending demand for data, and capacity is limited. The costs of data collection and dissemination should be assessed relative to the benefits for policymaking.
- *Not a one-size-fits-all approach:* Countries vary widely in their ability and willingness to prepare and report on budgets and budget execution. Similarly, development agencies reporting on donor commitments and disbursements may have different internal information systems and willingness to share information. Any attempts to improve systems must realistically take into account these varying starting conditions.
- *Importance of private flows:* Multiple types of private flows – from out-of-pocket spending to pharmaceutical sector contributions – are important to a full understanding of financing. In particular, establishing a way to value the in-kind contributions of the pharmaceutical sector is becoming an increasingly important task, but is quite difficult to obtain.
- *Focus on collective action:* The provision of information is a public good. It is unrealistic to expect that independent actions of individual agencies or governments will provide the optimal supply of information. Some type of collective action is therefore required that includes the necessary funding and governance mechanisms consistent with the concept of a public good.

## 7. Global Health Resource Tracking Working Group

In an effort to improve the information base for policymaking, the Global Health Policy Research Network (PRN) of the Center for Global Development (CGD) has convened the Global Health Resource Tracking Working Group. The World Bank, WHO and the OECD are involved in supporting and contributing to this Working Group.



# FOLLOWING THE MONEY: RECOMMENDATIONS FOR GLOBAL HEALTH RESOURCE TRACKING

By Global Health Resource Tracking Working Group, Paris, November 2005

## I. Introduction

Lack of information on health sector financing means people in developing countries are missing opportunities, through improved policymaking, to get more health for the money spent. At a global level, donors lack the information needed for effective coordination, and it is not possible to know if they are effectively realizing their commitments to provide more financing to help more countries meet the Health Millennium Development Goals. This report calls for actions that would create a more coordinated and policy-responsive system to track financial flows in global health at both global and country levels. These actions include strengthening government budgetary and financial systems in the developing world; institutionalizing national health accounts as the framework to track resources spent on health; and providing more timely, predictable and forward-looking data on external assistance to the health sector.

Good planning and policymaking in the health sector require timely, accurate information about spending on inputs and services as well as funding in the near- and medium-term. Mobilizing resources to accelerate progress toward the Millennium Development Goals depends on an ability to determine how funds are allocated and measuring the results that are achieved. While some routine data are available on total health expenditure (divided into public and private spending) for most countries, more timely, complete and detailed data are required for policymaking. In many developing countries, neither government agencies nor development agencies have routine access to such information at a level of detail that is useful for answering key policy questions. This information gap contributes to governments using incremental, rather than strategic, approaches to health sector budgeting and so missing opportunities to get more health for the money.

At the global level, donor agencies, aid analysts and advocates use “best guesses” about how much funding is available relative to what would be required

to achieve both near- and long-term health goals.

Lack of credible estimates of donor commitments and actual funds available to global health programs greatly impedes planning and advocacy efforts.

Data systems and access to information lag behind the rhetoric of greater transparency and accountability in international agencies. For many health areas, both funders and observers find it impossible to know whether the development community is living up to its commitments to provide greater and more effective transfers of development assistance.

These problems can be solved. The combination of political commitment, methodological advances and modern information technologies could produce a step-change in collection and dissemination of information about resources within the health (and other) sectors.

## 2. The problem

Despite progress toward greater availability of data and analyses on public sector health budgets and expenditures, information about health sector resource flows resembles a poorly sewn patchwork quilt, with many essential pieces missing. These are major weaknesses at the country level and the global level:

### a. Weak country-level information systems

- National Health Accounting (NHA) exercises, many supported by donors, have not yet realized the method's potential. Few countries have been able to integrate the collection and use of data on public and private expenditures into the routine business of policymaking and program implementation. Such institutionalization is hampered by lack of resources, lack of in-country capacity, and lack of coordination among donor agencies. In addition, decision makers often do not fully appreciate the utility of NHA for policymaking.
- The source data for expenditure tracking exercises suffer from problems of timeliness, comprehen-



siveness and accuracy. Few low- and middle-income countries adhere to sound public financial management and reporting practices.

- Despite the fact that private spending can account for half or more of all health expenditures, information on private spending is hard to obtain. Surveys that seek to capture information on household spending tend to be expensive, infrequent and subject to significant measurement error.
- Lack of information about spending on services and programs concerns donors that are shifting to sectoral and general budget support. Without such data it is impossible to know whether spending patterns are consistent with Poverty Reduction Strategies and commitments to greater, more equitable and more effective social sector investments.

#### **b. Limited global-level information systems**

- Detailed information about how much donors are committing and spending on priority health programs in specific countries is available mainly retrospectively, through cumbersome questionnaire-based exercises. Timely information is not readily available on domestic financing of health in developing countries. This lack of data significantly impedes the work of advocacy groups seeking to mobilize resources and monitor the gap between available and needed resources; and of officials in donor agencies who wish to understand the broader landscape of spending on global health so that they can better allocate resources.
- The OECD/DAC Creditor Reporting System was not designed for sector-level policymaking and so cannot respond to increasing demands for more timely and detailed information about donors' spending by type of health program. More flexible use of data resident in agency financial and activity management information systems might improve timeliness and disaggregation into policy-relevant categories.

### **3. The response so far**

For country-level expenditure tracking, major advances have been made in the development of proven national health accounting methods that permit cross-national comparisons and inform major health financing and policy questions. Tracking exercises focused on AIDS and other specific

diseases (called “sub-accounts”) have provided information that is valuable for both donor and national policymaking.

At the global level, the WHO NHA database publishes information for its member states annually on indicators of health expenditures including external flows spent in the country for its member states annually. These indicators are produced by accessing publicly available figures on spending in general, including those on health. However, these indicators are at the macro level and do not routinely report on subaccounts. In addition, improvements have been made in the OECD/DAC's ability to capture both disbursements and commitments of external resources on aid activities.

Major problems remain, however. Efforts to increase information about financial flows in global health have been undertaken in a relatively uncoordinated manner, and some of these efforts have given limited attention to the quality of the primary data sources. At the country level, much of the primary data from the public financial management system is of inadequate quality. Among organizations working on national health accounts, there has been only limited success to date in generating national-level demand for and institutionalization of expenditure tracking; and sub-accounts exercises often are not well integrated into a broader NHA framework.

At the global level, organizations interested in the flow of donor funds have launched a veritable barrage of efforts to collect data from donor agencies about individual health conditions and interventions – from AIDS to malaria to tuberculosis to immunization to health R&D to reproductive health to child health. This trend risks overworking and exhausting the patience of those who are faced with an onslaught of data requests, degrading the quality of all data collection and confusing policy audiences who may be unfamiliar with the potential shortcomings and unofficial nature of the data. Moreover, major sources of resource transfers, including private charities and the pharmaceutical sector, are not included in most data collection efforts.

### **4. Toward a solution**

The Global Health Resource Tracking Working Group sought to identify ways to accelerate progress toward a coherent, effective resource tracking system. This document summarizes core recommen-

dations about actions the international community should support to improve in resource tracking. The full working group report, to be finalized by early 2006, will include more detailed information about how these actions might be undertaken through public, private and academic institutions.

Several **core principles** underlie the recommendations:

*i. Place the highest priority on responding to needs of in-country decision makers*

Ensuring that the data in-country decision makers require for sound policymaking are available, with the timeliness and in the form that corresponds to the countries' budget and policy constructs, merits the largest investments. At the country level, there is need to build on existing assets, systems and resources, and strengthen these to more effectively respond to local needs. Moreover, the Paris Declaration on Aid Effectiveness commits donors to rely increasingly on countries' public financial management systems to monitor and report on their aid flows, including for the results that they help to achieve.

*ii. Coordinate, collaborate and do no harm*

Donor and other international agencies can advance the cause of better information systems in part simply by not making a bad situation worse. This means, for example, fighting the temptation to create duplicative data collection efforts to expeditiously respond to short-term information needs, and to instead build on existing systems. It also means finding ways for multi-agency collaboration and coordination in the methods used and additional support for institutions with the mandate for data collection, analysis and dissemination. It further means, however, sensitivity to the reality that without additional resources, these institutions can only be tasked to undertake a small marginal effort without degrading the quality of their work as a whole. Finally, it means that these institutions themselves must become more quickly responsive to new information needs.

*iii. Make the best use of modern information management technology*

Management and activity information systems both in some donor agencies and in some middle-income countries are structured to permit automated collection and reporting of policy-relevant information. As such systems are replaced and upgraded, with improved search functions, the

accuracy and comprehensiveness of data reporting can be increased and time lags reduced. The use of unobtrusive measures, such as data-mining and data-weaving, have the potential to yield more detailed information.

*iv. Think long-term*

Although there are some immediate ways to make progress, development of a functional, policy-responsive integrated system to track resources is a long-term proposition. It will require not only a resource commitment, but the patience to work within a common framework of action that will allow consistent information to flow from different information systems and be widely available.

## 5. Specific recommendations

### Recommendation 1: Support improvements in the ability of developing country governments to develop sound budgets and report on their execution

a) Reinforcing political commitment at the country level, donors and technical agencies should support the strengthening (and where needed rebuilding) of budgetary processes so that they become more policy based and, hence, fully engage political leadership. In particular, donors should support and use the Medium-Term Expenditure Framework mechanism to:

- Effectively link policy making, planning and budgeting
- Strengthen a medium-term perspective to budgeting
- Build links between inputs and outputs
- Develop budget processes, systems, structures and data that link inputs to results through the budget cycle

b) Donors and technical agencies should support developing countries with a unified approach to public expenditure management reform, taking as the point of departure the Performance Measurement Framework for Public Financial Management of the Public Expenditure and Financial Accountability (PEFA) Program. Of the 28 indicators in the High-Level Performance Indicator Set, particular attention should be paid to the credibility of the budget (budget estimates to actual expenditure); budget transparency; political engagement in budget decision making; the quality and timeliness of in-year budget reports; and the effectiveness of external audit.

- c) In keeping with the Paris Declaration on Aid Effectiveness, donors should seek means to:
- Provide complete and forward-looking financial information for budgeting and reporting on projects and programs and budget support being supported in a country
  - Manage aid through national processes of policy, planning and budgeting
- d) As national financial management systems are being strengthened, donors should work with relevant ministries to support the tagging of expenditure, including through “virtual poverty funds” to help focus on the role of the budget in supporting poverty reduction.
- e) The work of strengthening national financial management systems should be closely coordinated with the institutionalization of National Health Accounts at the country level. This will involve constructing explicit linkages between budget and NHA expenditure classifications, assuring that data collected on a “routine basis” for expenditure reporting are also used for NHA and that financial management systems are responsive to the needs of NHA.
- f) Donor and technical agencies should coordinate to assure that NHA is integrated into and builds on ongoing efforts including among others the Health Metrics Network, Virtual Poverty Funds, MTEF, and PEFA. For example, in the preparation of Public Expenditure Reviews, the World Bank and its partners should make use of existing National Health Accounts data or, when NHA data are unavailable, support the collection of data using the standard methods.
- g) Donors should explore ways to support local civil society organizations to build their capacity to analyze budgets and monitor their implementation. This “watchdog” function can be an extraordinarily effective means of stimulating and reinforcing good budgeting and expenditure tracking practices within the public sector. In addition, donors should support the selective use of methods to track expenditures to the facility level, to enhance accountability of the public purse.

## **Recommendation 2: Support the integration and institutionalization of National Health Accounts into policymaking in developing countries**

- a) Donor and technical agencies should cease to compete and reduce the confusion about different methods for tracking health expenditures. They

should clarify and reiterate their support for tracking of health expenditures within the NHA framework that is responsive to country needs and permits cross-national comparisons. Efforts to develop disease-specific spending assessments or “sub-accounts” should support the broader agenda of creating the capacity, demand and methods for national health accounting in addition to responding to the countries’ needs for timely and policy-relevant disaggregated information.

- b) Donors and technical agencies should support the integration and institutionalization of health expenditure information into national and sub-national policymaking by:
- Working with in-country partners to identify an institutional “home” for NHA to move it from a “project activity” to a routine function of the government. Countries should be encouraged to start with basic information under the NHA framework and expand gradually as the needs for policy arise.
  - Using resources from the Health Metrics Network and other sources to support the development of capacity (including expertise in health management information systems and financial/accounting systems) to track and report on financial resource flows.
  - Ensuring that technical assistance for health accounting includes expertise in health management information systems and financial/accounting systems.
  - Strengthening capacity development (training) within the institutions responsible for undertaking health accounting exercises, as well as disease-specific resource tracking, both at national and state/provincial levels.
  - Working to integrate health accounting classification into improvements in public budgeting and expenditure tracking systems.
  - Designing and monitoring surveys to track expenditures on health from all government authorities (including ministries other than health), non-governmental organizations and private and public corporate sector spending.
  - Using data on health expenditures in strategic planning exercises, including joint activities between donors and government ministries (e.g., Poverty Reduction Strategies, sector-wide planning exercises, and others).
  - Providing or helping to mobilize sustained funding for regional networks and institutions that offer regional and local expertise, encour-

aging these networks and institutions to provide opportunities for professional exchange on methodological questions, as well as sharing of experiences about communication of analytic work to policymakers and how information on health expenditures has been used for policymaking.

### **Recommendation 3: Improve data on private spending**

- a) Donors and technical agencies should provide technical and financial support to adapt routine household surveys so that they capture information about private health expenditures and utilization of health services. This would include the development and/or refinement of methods so that cross-nationally comparable spending estimates can be generated, potentially with coordination through the International Household Survey Network, housed at the World Bank. Support should also be expanded for ongoing work in select environments to improve transactional data collection from service providers and insurers.
- b) A valuation roadmap for in-kind contributions by pharmaceutical companies should be developed, and should include concessional commodity sales, voluntary licensing, transfer of manufacturing, R&D, M&E or other technological know-how; and commodity and service donations.

### **Recommendation 4: Support and refine global-level information systems**

- a) Donors and technical agencies that have promoted and/or provided financial support for single-disease tracking surveys of donors should avoid continuing the proliferation of such activities and adopt a more coordinated approach ensuring adequate response to the evolving needs of high quality, pertinent and policy-relevant information. They should aim to draw on agency classification systems to define policy-relevant categories that respond to the majority of requests to major donor agencies for their spending on health by sub-sector, while recognizing that as more donors move to sector-wide and general budget support such detailed information is becoming less available. Nevertheless, the prospects for more timely data on planned and actual flows to the overall health sector are good.
- b) The OECD/DAC should build on the Working Group's background analysis to expand the survey of donor agencies' accounting and reporting

practices. The survey would describe and analyze individual agencies' budget frameworks, timing of finance-related decisions, type(s) of aid transferred, sector and sub-sectoral priorities and data breakdowns, use of policy markers, integration of information technologies, use of commercial information technology applications, and so forth.

- c) The survey should investigate a method to "map" or "crosswalk" the within-agency classification system to policy-relevant categories in a way that permits valid comparisons. Public and/or private donors should support refinement of such a map for its application across sectors, and the development of automated tools (information systems) to do the mapping on a periodic and frequent basis, as data are provided by the donor agencies (e.g. quarterly).
- d) The findings from this survey could form the basis for a sequenced enhancement of the reporting of donor commitments and disbursements to be forward-looking and more timely to support improved predictability, as called for in the Paris Declaration.
- e) Subject to available funding, the OECD/DAC should be supported to develop the capability to be a portal for public access to detailed and frequently updated data on donor commitments and disbursements. Data would be required not only from OECD/DAC member countries, but also for tracking the bilateral flows from non member countries and flows from private foundations and other agencies.
- f) Dependable financial support should be provided to WHO and other relevant agencies as appropriate for the collection, validation, compilation and timely electronic dissemination of a basic set of indicators of health expenditures in countries. Within this context, coordinated efforts should be made to routinely update harmonized methodological norms and provision of technical assistance where necessary to ensure comparability of these estimates.

This document was prepared by the Global Health Resource Tracking Working Group, which was convened by the Global Health Policy Research Network, a program of the Center for Global Development [www.cgdev.org](http://www.cgdev.org)

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# IMPROVING HEALTH WORKFORCE PERFORMANCE

By Peter Sandiford, Geneva, January 2004



## I. Introduction

Scaling up interventions to meet the Millennium Development Goals depends on effective health services delivery systems. The availability of health workers, their skills, attitudes, motivation and behaviour are all key to a well-functioning health service delivery system.

Evidence suggests that in many poor countries the number of health workers is grossly insufficient for the implementation of priority interventions according to needs. Paradoxically, countries, which face the highest disease burden, are those with the lowest numbers of health staff per population. Most are low-income countries in sub-Saharan Africa, where the HIV/AIDS epidemic has driven health services into collapse by greatly increasing workloads and by hitting health workers. Furthermore, emigration of qualified health personnel is another key factor in the weakening of health service delivery systems. If the situation is not rapidly addressed, the consequences will be grave. Additional funds raised for the scaling up of priority interventions will not be disbursed, significant health improvements will remain out of reach, and governments and donors will not be able to translate their commitment to the MDGs into reality.

The policies and practices of health development partners are of utmost importance. Too often, they have contributed to the neglect of health workforce issues. The primary focus of donors has traditionally been on the projects/programmes they have funded and not on ensuring that health systems are strong enough to address the needs of populations. As sector support remains unpredictable and usually precludes funding for worker compensation, the ability of governments to invest in their health workforce is limited. Preference is often given to disease specific programmes that are not well integrated in health delivery systems. Such programs and initiatives contribute little to the building of a motivated and appropriately skilled workforce and any training activities are limited to the relatively small number of program staff. In addition, these

programmes frequently “poach” staff robbing governments, administrations and services of their most talented and skilled employees. If they are prepared to change these practices, disease specific programmes could make a significant contribution to the development of workforce capacity and performance.

The development of an effective health workforce requires country specific solutions built on sound situational analysis. In countries where the health workforce is in crisis, urgent action plans are needed to identify interventions that can resolve key constraints in the short to mid-term. Mid-term strategies must comprehensively address shortcomings of health workforce performance. They need to address the human resource implications of ongoing health and public sector reform programmes and lay out interventions and policies that can be mainstreamed in sector and country-wide development strategies such as Poverty Reduction Strategies. They must assess the cost and fiscal implications and reconcile them with public expenditure frameworks. Parallel investments are needed to build the institutions and capacity required to implement such strategies and monitor and evaluate their impact.

A paradigm shift is required from governments, development partners, and other stakeholders. Investing in the workforce can require substantial increases in recurrent expenditure on health, but it can also bring much needed benefits. Governments and development partners alike face a challenge to mobilize the required financial and political resources. If solutions are at odds with public expenditure and macroeconomic frameworks, alternatives need to be considered.

The Joint Learning Initiative on Human Resources for Health launched by the Rockefeller Foundation and supported by many important donors and technical agencies is compiling and summarizing the current knowledge base. Substantial and critical information gaps will remain, and continued global learning, with a focus at the country level, will be



important for the development of innovative and improved strategies, policies and practices. Such a learning agenda would include the development and application of standardized diagnostic tools, the monitoring and evaluation of the impact of policies and practices and selected operational research to fill the most critical information gaps.

Today, the health workforce performance is a binding constraint for accelerated progress towards MDGs in most poor countries. It is time to take action. The World Bank and the World Health Organization, and their partners, are committed to a participatory process that will result in a global action plan to address key health workforce issues. This will require the mandate, the participation and the financial commitment of all health development partners.

## 2. Improvement in health workforce performance is critical to achieve the health related MDGs

The number of health workers in a country is the main indicator of its capacity to deliver services and varies substantially among countries. In Monaco, for example, the number of physicians per 100,000 population is 664 compared to just 2.3 in Liberia<sup>1</sup>. While the optimal number of health workers per population is unknown, it is evident that in many poor countries the number is grossly insufficient for the widespread implementation of a minimum of lifesaving interventions. The Ministry of Health of Botswana estimates that achieving universal coverage of anti-retroviral treatment alone would require doubling the current nurse workforce, tripling the number of physicians, and quintupling the number of pharmacists<sup>2</sup>. Recent research shows that the workforce needs to triple in Tanzania and more than quadruple in Chad to deliver priority interventions at the national level by 2015<sup>3</sup>. In 1998, the vacancy rate for public facility physicians was 43% in Ghana and 36% in Malawi. Lesotho reported the public sector nurse vacancy rate at 48% in 1998, and Malawi at 50% in 2001<sup>4</sup>.

Ironically, the countries with the highest disease burden are also those with the lowest numbers of staff per population ratios. Most of them are low-income countries in sub-Saharan Africa, where the HIV/AIDS epidemic has led health service delivery systems to collapse due to its impact on health workforce performance. The epidemic increases the need for services and health workers, while causing death and disability within the labour force. It has a harm-

ful impact on the working conditions of health workers and often leads them to resign. It deters students from enrolling in training programs for health professionals and further destabilizes the balance between intake and loss of personnel.

Low staff per population ratios and high vacancy rates are the result of an insufficient supply of health workers and inadequate resources to attract and retain them in service. Emigration is a key source of workforce attrition in low-income countries. Health workers with internationally accepted degrees are attracted to positions in industrialised countries by better remuneration, career opportunities and active recruitment campaigns. In Zambia, of the more than 600 doctors that have trained since independence, only 50 remain in the country and in Ghana more than 50% of physicians who trained during the 1980s now practice abroad<sup>5&6</sup>. The UN Conference on Trade and Development estimated that 56% of all migrating physicians flow from developing to industrialized countries, while only 11% flow in the opposite direction. The imbalance was even greater for nurses<sup>7</sup>.

The effectiveness of the workforce, however, depends mostly on the productivity, quality and deployment of an adequate number of health workers. Inappropriate health worker behaviour, resulting from low motivation and inadequate training, can cause significant service inefficiencies. For example, absenteeism rates in public facilities are reported at 29% in Peru, 35% in Bangladesh and 43% in India<sup>8&9</sup>. Studies from Tanzania and Chad indicate that staff in public facilities spend only 55% to 60% of their time on tasks they are trained to perform. Quality is often woefully inadequate. In Burundi in 1992, only 2% of children with diarrhoea taken to a health facility were correctly diagnosed. In the same facilities, only 13% of children who were correctly diagnosed with diarrhoea were correctly re-hydrated<sup>10</sup>. A common cause of insufficient quality is the substitution of skilled with unskilled labour. According to national staffing norms, Tanzania has an excess of 5,000 unskilled health workers and a shortage of 8,000 health professionals. One interpretation of these findings is that an unskilled worker performs every fourth task that requires a skilled health professional.

Access to services can be significantly limited by the uneven deployment of health workers. In Nicaragua, approximately 50% of the country's health workforce is concentrated in the capital Managua where only 20% of the population resides. In Tanzania, the nurse per 100,000-population ratio

in the urban districts of Dar es Salaam is 160, which is sufficient to meet the demand for primary, secondary and tertiary care, including care of patients after neuro-surgical interventions. However, some districts have less than 6 nurses per 100,000, which is insufficient to deal with the daily number of new malaria cases. In Zimbabwe, whole districts are left with only one physician and in Indonesia vacancy rates in public health centre in remote areas reach 60%.

While workforces in many countries are in a critical condition, some improvements in quality, productivity and deployment of health workers could significantly improve service delivery and thus accelerate progress towards the MDGs. Without addressing these issues however, additional funds raised for the scaling up of priority interventions will not be disbursed, significant health improvements will remain out of reach, and governments and donors will not be able to translate their commitment to the MDGs into reality.

### **3. Changing realities generate new challenges and call for new approaches**

Two decades ago, human resource development was straightforward in most developing countries. Governments simply needed to produce sufficient health workers to meet the needs of expanding public health services. Today however, a range of diverse private providers exist and people seek care from public, private for-profit and a wide variety of not-for-profit providers, such as non-governmental, community and faith-based organizations. Each mode of provision represents an alternative job opportunity for health workers, with varying salaries, benefits, career opportunities, and working and living conditions. At the same time, the Internet has increased access to information about employment opportunities nationally and internationally and even in different labour markets.

Faced with these changes, governments are now required to assume a fundamentally different role in the development of human resources for health. With the emergence of complex health labour markets, governments now face the challenge of ensuring that the level of employment and the distribution of the workforce are coherent with health sector objectives. An unregulated health labour market is not efficient and government intervention is justified and required.

The labour market perspective has changed the basic approach to human resources development.

The performance of the health workforce needs to be understood as the aggregate outcome of worker choices. Solutions to workforce issues have to identify and address the factors that determine the choices and behaviour of health workers, such as their needs, values and expectations. It is important also that health workers play an active role in the development of policies, which will affect the environment in which they are expected to work.

### **4. The current knowledge base allows for action on key workforce performance issues**

These are new challenges, but the current knowledge base provides sufficient evidence to guide governments and stakeholders in the development of action plans that will address key workforce issues. Interventions in a few key areas could lead to significant improvements.

In countries with significant shortages, the supply of health workers must be increased. Investment in training can expand health worker supply in the mid-term. The liberalization of immigration and incentives to attract foreign workers can mitigate shortages in the short-term. While supply is being increased, losses must also be reduced. For example, investments in the well-being of health workers in countries substantially affected by the HIV/AIDS epidemic can mitigate the losses due to ill health and death. New positions must be created and incentives provided that attract and retain health workers in service. Policies and practices must also ensure the adequate quality, productivity and deployment of the health workforce.

Differentials in compensation, working conditions and associated living conditions determine in which sector, at what level of care and where health workers seek employment. Improved incentive packages can retain staff in the public sector and in the country and can attract staff into primary care services or rural areas. The introduction of an additional duty hour allowance in Ghana, for example, fostered overall job satisfaction and attracted physicians from the private to the public sector. In Thailand, generous research funding and monetary incentives reduced the 'brain drain' of medical professionals.

Under some remuneration packages, the final income level depends on the behaviour of health workers. There is evidence that performance related pay, such as fee-for-service, increases the productivity of physicians, but that they also tend to create

demand for unnecessary services. In Brazil during the 1990s, for example, delivery services were reimbursed on a fee-for-service basis. When the fees for a caesarean section substantially exceeded the fees paid for a normal delivery, the incidence of caesarean sections increased far beyond justified levels. This suggests that new incentives should be introduced with care.

Strengthening leadership, management, supervision and accountability can enhance health worker motivation and performance. Health workers in India value challenging work, recognition by superiors and sufficient time for their personal life as much as good remuneration. In Bolivia and Vietnam, community monitoring of health services has been shown to help ensure that health workers meet the needs of the community, thus improving the availability and quality of services.

The content of education and training programs is critical for performance. The quality of curricula determines whether health workers are prepared for the tasks and challenges they face and thus are primary determinants of service quality. Also, graduates who received extensive training in family medicine are more likely to settle and practice in remote areas. As training is clearly valued by health workers, improving access to continuous education programs improves not only service quality, but increases job satisfaction.

Where there are shortages of health staff, alternative modes of service delivery can ease the strain on the health workforce. Changes in technology can allow for the substitution of higher skilled with lower skilled staff in the provision of clinical services. Algorithms to diagnose and treat childhood illnesses or sexually transmitted infections enable nurses and midwives to deliver services traditionally provided by physicians. Standardized, population based services such as vector control, immunization, vitamin A supplementation, antenatal care and oral re-hydration can be delivered through health workers with limited training at the community level. In 1987, the local authority of Ceará in north-east Brazil, started to recruit, train and deploy community health agents. Within a few years, agents were visiting 850,000 families per month and some of the significant decreases in infant mortality could be attributed to the services provided by them. Some interventions lend themselves to provision outside the health sector. Condoms and insecticide-treated nets have been successfully marketed through retail systems in various countries.

In countries with limited access to public services, governments must engage the whole sector in the provision of priority services. This includes contracting private providers and mobilizing community and civil society organizations. With such a sector-wide approach, government regulation of the private sector becomes even more important to ensure service quality.

Although current understanding of the situation is sufficient to initiate action, further research is needed as significant information gaps remain. For example, although we are beginning to understand the factors that contribute to job satisfaction, we know little about the responsiveness of health workers to changes in incentive schemes. There is little evidence that performance management systems affect service quality or health outcomes or that efficiency gains exceed the costs of setting up and running such systems. Investment in research is required to fill information gaps and to strengthen systems that monitor and evaluate country action plans and their impact. Systems must be developed that can disseminate and use findings in order to ensure a continuous improvement in policies and practices.

## **5. The sustained commitment of all stakeholders is essential**

Policies initiated outside the health sector can have a tremendous effect on the health workforce. Unfortunately, the impact is often not in line with health sector objectives. In Tanzania, during the 1990s, the public sector employment freeze and retrenchment actions under the structural adjustment programme effectively pruned the workforce of staff deemed irrelevant for service provision. At the same time, however, the size of essential cadres shrank in relation to the population size and to increasing health needs, leaving a workforce that was overworked, demotivated and grossly insufficient for scaling up priority interventions. As the wage bill typically consumes 60 to 80% of recurrent expenditure on health in poor countries, mobilizing additional resources for investment in the workforce is potentially at odds with prevailing public expenditure and macroeconomic policy frameworks. To turn the tide in countries with substantial shortages, it will be critical to consider alternative expenditure frameworks and budget neutral sources of funding such as debt relief.

Similarly, reforms and policies driven by sector objectives need to recognize their potential impact

on the workforce. In 2002 in Bolivia, the transfer of contracts from the central to local government as part of a process of decentralization met the stiff resistance of public health workers in Bolivia. Health services remained paralyzed during strikes that lasted almost two months and was only resolved by the government abandoning the transfer of contracts.

Policies and practices of health development partners can also have a considerable impact on the workforce. As sector support remains unpredictable and precludes funding for compensation, the ability of governments to invest in the workforce is limited. Payment of high per-diems to ensure their attendance at workshops and seminars has created a business that distracts managers and staff from service priorities and discourages those without the opportunities to benefit. Policies of development partners often favour disease specific programs that are not well integrated in national health delivery services. Such programs and initiatives contribute little to the building of a motivated and appropriately skilled workforce. Training activities are limited to the relatively small number of programme staff. “Poaching” of staff robs governments, administrations and services from their most talented and skilled employees. In some instances, vertical programs even paralyze regular service provision, such as in Madagascar where national immunization days leave rural health facilities completely void of staff. With a few changes, disease specific programs could make a significant contribution to the development of workforce capacity and performance. For example, programmes currently being launched that aim to scale up anti-retroviral treatment in poor countries will create a substantial increase in demand for health labour and therefore a need to invest in training to prevent the draining of staff from regular services and other initiatives. If implemented in an integrated way, and articulated with pre-service education, the required training of staff can have a tremendously positive impact on other services to patients at risk or infected with HIV. The programmes provide the opportunity to introduce alternative delivery models into the public sector, for example, new business and management models, the contracting of private providers, and the use of community resources.

With such a wide range of policies and practices affecting the workforce, only an alliance of governments, development partners and other relevant stakeholders in health, education, public service reform and finance can create an environment that is conducive to improvements. Models of good practice are emerging from Latin America where 17

countries, assisted by Pan-American Health Organization (PAHO), have established Observatories of Human Resources. These facilitate knowledge sharing and dialogue among all stakeholders. They foster the recognition of workforce issues in the wider policy context, promote broad consensus and ensure political feasibility.

A comprehensive approach and sustained commitment are vital to bring about improvements. Causes of poor workforce performance are interconnected and single interventions will have only a limited impact. Low motivation and morale in the public sector can be the result of various unmet expectations, such as low remuneration, poor working conditions and lack of access to education. It discourages graduates from enrolling in training institutions for health professions; it encourages absenteeism and health workers to leave the public sector and seek work in the private sector or in other professions or to leave the country to work abroad. Significant changes as a result of interventions to address workforce shortcomings will unfold only over the mid-term rather than the short-term. Increases in training capacity or improvements in training curricula, for example, will not result in increased supply or the availability of better skilled staff until after the length of the training period. Only a comprehensive approach sustained over years will produce tangible improvements. Such an approach requires continued financial and political commitment of all stakeholders.

## **6. A call to action for governments and donors**

While the focus on improving health service workforce capacity must be at the country level, actions at the global level are also needed to facilitate and enhance national efforts and to address issues that are beyond the control of individual countries.

There is a need for a paradigm shift among governments, development partners, and other stakeholders. Priorities, policies and practices must be re-evaluated and amended so that they do not undermine but contribute to the development of effective workforces. Improving the health workforce performance will require significant investment and increases in recurrent expenditure on health. Governments and development partners alike face the challenge of mobilizing the required resources. If solutions are at odds with public expenditure and macroeconomic frameworks, alternatives need to be considered.



Mitigation of the effects of international migration of qualified health workers from poor countries are largely beyond the control of individual governments and require global action. Guidelines for international recruitment must be developed, strengthened and then enforced. Compensation, working conditions and training capacities in countries with substantial inflows need to be improved to augment the local supply of health workers. The newly established UN Commission for Migration should be able to play a critical role in monitoring international migration in health and the development of solutions to adverse effects.

The Joint Learning Initiative on Human Resources for Health launched by the Rockefeller Foundation and supported by many important donors and technical agencies is compiling and summarizing the current knowledge base on health workforce performance and its determinants. However, sub-

stantial and critical information gaps remain. Continued global learning with a focus at the country level will be important for the development of innovative and improved strategies, policies and practices. Such a learning agenda needs to include the development and application of standardized diagnostic tools, the monitoring and evaluation of the impact of policies and practices and selected operational research to fill most critical information gaps.

Today, health workforce issues are a binding constraint for accelerated progress towards MDGs in most poor countries. The World Bank, the World Health Organization and their partners are committed to a participatory process that will result in a global action plan to address key issues over the next twelve to eighteen months. This, however, will require the assent, the participation and the financial commitment of all health development partners.



# WORKING TOGETHER TO TACKLE THE CRISIS IN HUMAN RESOURCES FOR HEALTH

By Lincoln Chen, Tim Evans, Sigrun Møgedal and Francis Omaswa, Paris, November 2005

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## 1. Introduction

This paper summarizes the rapidly accumulating evidence and growing recognition of the crisis in human resources for health (HRH), especially in sub-Saharan Africa. The nature of the crisis is briefly outlined, drawing attention to escalating activities, demand and momentum emerging from Africa and other countries calling for appropriate and effective global and regional support. There is a clear need for quality technical work, stronger regional cooperation, harmonization of health systems and global initiatives, and for sound fiscal and migration policies. Underscored is the growing gap between energetic yet isolated and fragmented country efforts and appropriate and effective external reinforcement.

In an inherently complex field with weak data, an underdeveloped evidence base and isolated and fragmented activities, the necessity for multi-sectoral policy development is acute. Building on ongoing collaboration among stakeholders, catalysed by the High-Level Forum, the Oslo Consultation, the Joint Learning Initiative (JLI), the WHO and the World Bank, bilateral and nongovernmental bodies, and regional networks, a global alliance is emerging, not as a separate new organization but an alliance built on collaborative linkages across existing and new actors. Energized by key leaders with agile operations based in existing institutions, it is anticipated that this alliance would be open to the co-equal participation of all actors. A concrete set of deliverables for this alliance over the next several years is proposed within a vision and mission on how to tackle the crisis in HRH for advancing global health equity.

## 2. Dynamic contexts

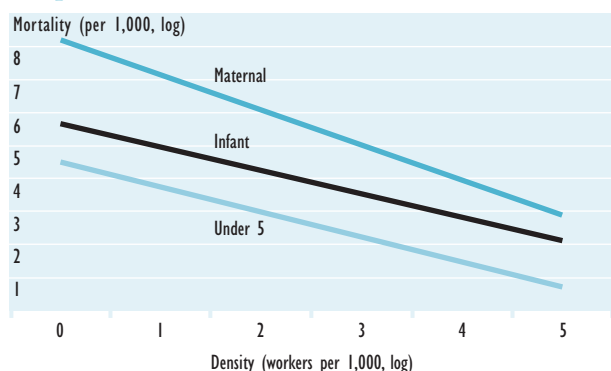
At the first High-Level Forum in Geneva in January 2004, the imperative of overcoming the crisis in HRH in order to achieving the health-MDGs was acknowledged. By the second High-Level Forum in Abuja in December 2004, African leaders were unified in their support for country-led and country-

based action, and also firm in their view that progress depended in part on significant international response. In support of this approach, a rapidly assembled Oslo Consultation in February 2005 engaged key stakeholders in order to achieve consensus behind a “common global platform of action.” A Transitional Working Group (TWG) was established to broaden the consultation process, to promote interim actions, and to develop an action plan. At the third High-Level Forum in Paris in November 2005, the TWG reported on progress and discussed ways to advance collaboration in order to overcome the crisis in HRH.

Whether viewed from the perspective of a patient who is ill and in need of urgent care but who is denied access to essential services due to the absence of a health worker, or whether viewed from the perspective of an over-stretched health worker who is inadequately equipped, bringing barely poverty-level wages back to her family, the problems in HRH are longstanding exacerbated by fresh forces taking on new forms. In the poorest countries of sub-Saharan Africa, HIV / AIDS is a “triple threat” – it generates huge work burdens, it has a direct impact upon the lives of health workers through personal or family illness, and it places stress upon the workforces as workers become terminal care providers rather than healers. Unrelenting demand for skilled workers in an expanding global labour market has provided fertile ground for the acceleration of the migration of professionals from rural to urban areas, from the public to the private sector, and from many of the hardest-pressed countries to greener pastures. And the past two decades of “structural adjustment” and “health sector reform” have paid insufficient attention to health workers who were often seen as fiscal liabilities rather than core assets of health systems. Health care is fundamentally a “service industry” that by necessity relies on a motivated, skilled, and supported workforce.

These developments are among the reasons why the World Health Assembly in both 2004 and 2005 passed resolutions, at the initiative of African

**Graph 1 Workforce and health outcomes**



Source: Anand & Baernighausen (2004) in JLI (2004)

ministers of health, to address HRH. The case was well advanced by the report of the JLI, a coalition of more than 100 global health leaders comprising practitioners and scholars from both the South and North. With the scaling up of the AIDS response and a host of categorical programmes, managing HRH is central to addressing the additional and often competing demands on health workers for different tasks and between their frequently joint roles as public and private sector providers. Human resources are demonstrably linked to health systems outputs and health outcomes (Graph 1). Staff costs are often the largest share of health budget that is the least strategically planned and managed. The workforce is the catalytic lever for driving the performance of health systems and priority programmes. Although water, sanitation, nutrition, and other investments are equally important, a motivated and skilled workforce is critical for reducing maternal and child mortality, for managing HIV/AIDS, TB and malaria, as well as for the provision of essential preventive, diagnostic and curative services. Stated simply, there are no short-cuts around the issue of human resources for achieving the health MDGs.

Countries differ greatly in their human resource endowments. Yet as underscored by the JLI report, all countries confront a common set of challenges – severe shortages, maldistribution of workers, inappropriate skill-mixes, negative working conditions, and huge knowledge gaps. Over 600 million sub-Saharan African people are served by fewer than one skilled worker per 1000 population and less than 100,000 doctors in total (Graph 2). The JLI estimates that a density of 2.5 health workers per 1000 is necessary to hit key milestones such as 80% coverage of immunizations and skilled birth attendance. To reach these MDG targets, Africa would need to triple the number in its workforce – more than 1 million additional skilled workers. Simply pouring in more money

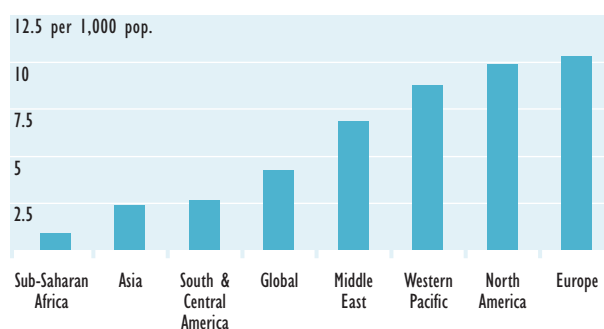
and more drugs will be useless or even wasted without dramatic improvements in the human infrastructure that enables effective health action.

Since High-Level Forum I, policy momentum for tackling the crisis has been steadily building at nearly all major international events. The momentum, predominately technical and programmatic, has also reached the highest political levels. HRH was identified as a key priority by African Heads of State in Abuja in January 2005, and the recent African Union meeting of health ministers in Gaborone in October echoed these priorities. Globally, the UK Africa Commission devoted a major share of its health recommendations to strengthening the workforce in health systems. The same political priority to HRH was echoed at the G8 Summit in Gleneagles in 2005 and reaffirmed at the September UN Summit for the MDGs.

Public attention in Northern countries has been further fueled by the media, and by NGO advocacy campaigns. The BBC, the New York Times, and the Guardian all have extensively featured the human resources in health crisis in Africa. Non-governmental organizations have been successful in bringing the workforce crisis into public focus and into policy formulation in the US congress, UK parliament, and other legislative bodies. Professional groups have also been active, with major coverage by leading medical journals like the Lancet and the British Medical Journal. Indeed, among the most active advocates for correcting the unfairness of migration depletion from the poorest countries has been the British Medical Association.

It should be recognized that the crisis in HRH will not simply “fade away.” Gross under-production of skilled workers is apparent in many of the countries hardest hit by the HIV/AIDS epidemic. Even in well-endowed countries, escalating demand for skilled workers and aging populations means

**Graph 2 Health workforce by region\***



\* Combined physicians, nurses, midwives per 1,000 population

Source: JLI (2004) compiled with WHO estimates of health personnel 2004

accelerating importation in an increasingly porous global labour market. Few countries, rich or poor, have strong human resource planning and implementation capacity to correct deficiencies that have been decades in the making. Not only is urgent action necessary but at least a decade of sustained investments will be needed to build a robust human infrastructure for most national health systems.

### 3. Escalating activities, demand, and momentum

Country activities “to train, retain, and sustain” national workforces are increasing, and a number of countries have undertaken innovative actions. African countries have initiated many situation assessments, research and studies, planning and policy development, and know-how transfers. Ghana, for example, has been leading the way through an additional duty allowance and financial and non-salary incentives for rural postings – to such a scale that these allowances now constitute nearly 40-50% of the salary bill in the public sector. Malawi has been making major efforts to strengthen its national workforce through major adjustments of compensation and work systems. Ethiopia is training more than 20,000 community health workers to extend basic services into rural areas. While detailed specification is difficult, some generic patterns are emerging (Box 1).

Novel activities in countries are generating growing demand for appropriate and effective regional and international support. Among the key areas of reinforcement are: (1) developing and sharing tools, guidelines, and best practices for strategic planning and management; (2) strengthening regional and global cooperation to achieve scale and impact; (3) relying on human resources to strengthen health systems and to harmonize global initiatives; and (4) developing supportive fiscal space and migration policies. These support requirements are discussed in turn.

#### a. Tools, guidelines, and best practices

HRH is an underdeveloped field where established norms, guidelines, and best practices have yet to be clearly established. As a consequence, most country activities are being launched without a strong evidence base of what works, why, and how. WHO and its regional offices have been playing increasingly critical roles in normative standard setting and technical excellence. But, more technical support to fledgling national programmes that would benefit from improved information, standards, and knowledge must be forthcoming. Core indicators of HRH must be developed, and all HRH policies and interventions must be monitored and linked to health systems outputs. In some fields, technical expertise already exists within Africa, in both the public and the private sector, and these regional resources need to be galvanized in support of national processes with appropriate international supplementation. Throughout, a culture of “learning communities” must be built and strengthened to actively engage in the trial-and-error of improving HRH planning and management.

#### b. Regional and global cooperation

Demand for country support is increasing exponentially, especially in Africa. The potential for sharing technical and institutional resources within regions is important even whilst additional capacity is being mobilized. For example WHO is proposing “The Connection,” an open network to mobilize technical expertise and to develop indicators, tools, and guidelines in support of country activities. Collaboration and linkages among key technical groups around the world are being fostered, including Liverpool Management Science for Health, the US Center for Disease Control, and various bilateral technical activities. A regional network of agencies sharing capacity and expertise in support of coherent and coordinated regional action has already been fostered through the Pan American Health Organization (PAHO). New regional initiatives are

#### Box 1 Recent initiatives in human resources for health and underdeveloped areas

Some recent initiatives	Some underdeveloped areas
<ul style="list-style-type: none"> <li>• Efforts at retention through salary, benefit, extra-duty allowances</li> <li>• Incentive payments for rural hardship postings</li> <li>• Outsourcing and new contractual arrangements</li> <li>• Expanding more flexible private systems</li> </ul>	<ul style="list-style-type: none"> <li>• Little mobilization of pre-service training</li> <li>• Skill-mix deficiencies are rarely addressed</li> <li>• Data deficiency and weak monitoring and evaluation</li> <li>• Few new policies and regulations</li> <li>• Infrequent engagement of stakeholders</li> </ul>

emerging in Africa sparked by the NEPAD/WHO/ACOSHED Conference on Human Resources held in Brazzaville in July 2005 and in Asia sponsored by the Thai Ministry of Public Health workshop held in Bangkok in August 2005. In Africa, the need to map the current situation and to collate and disseminate existing lessons on good practice has been realized. A strong case has been made for an African regional observatory on HRH.

### **c. Health systems and global initiatives**

Global initiatives have played an important role not only through the resources mobilized but also in focusing international attention on critical issues and accelerating progress towards the MDGs. However, there is now a need to ensure that these resources effectively complement and build health systems which are necessary for sustainability and for addressing the full range of essential health needs of a population. Productive dialogue with the leadership of the global initiatives has highlighted considerable willingness and commitment to harmonize behind national priorities. It is agreed that the co-operative arrangements between global initiatives and national plans of action should be designed to complement and strengthen – not duplicate or compete with – health systems. The bulk of external financing should flow directly into countries in support of national plans for health systems and priority programmes. While not a panacea, effective HRH management is critical for improving the efficiency and impact of these investments. Getting the right workers into the right place at the right time doing the right things is absolutely fundamental to health results. HRH, moreover, offers a powerful advocacy focus for highlighting fiscal space exceptionality, managing migration and harmonizing public-private dynamics. Most importantly, HRH operates as the common “currency” to bring harmony among health systems and priority disease programs. Ultimately, the priority that countries accord to the training, deployment and tasks assigned to workers is where health systems and global initiatives come together.

### **d. Fiscal and migration policies**

Critical to country level HRH action are policies on fiscal space to ensure sustainable financing in support of the health sector. This will be essential before ministries of finance will agree to take on the financial commitment of an expansion and improvement in the employment terms of the health workforce. Policies on labour markets, public sector

reform, and the implications of decentralization will all be critical in the formulation of country responses. So too, ultimately, will be improved management of international migration. Migration policies are indicated for both sending countries and receiving countries. The former must make a real commitment to broaden and retain professionals through stronger education, retention, and productivity strategies that expand the pool of appropriate personnel who are able to achieve employment and work in positive work environments. The latter must dampen the demand for the consumption of imported skilled workers through self-sufficiency in production. Unethical recruitment practices must be curtailed. Official Development Assistance (ODA) investments can play a critical role by earmarking significant external support for pre-service education and creating a healthy working environment in the poorest countries. Research will be essential for improving understanding and to support policy dialogue on these complex and politically contentious phenomena.

## **4. Working together**

In the same way that human resources represent the cement of the health system, essential for holding the various components together, coordinated action addressing the HRH crisis can effectively link and strengthen joint work between existing global initiatives. HRH provides a common unifying theme. Addressing the crisis in HRH requires a modality to accelerate more effective action – for without greater cohesion there are real risks of fragmentation, competition, duplication, and insufficiency. This is already becoming evident among the many new independent initiatives, often donor driven, that are neither well aligned with country priorities nor the investment policies of others.

Extensive consultations over the past year have emphatically endorsed the imperative of stronger cooperation to pursue a “country-led framework” to accelerate national planning and management. As an underdeveloped, multi-sectoral field beyond the purview of any single actor, a global platform is necessary to bring together stakeholders for HRH promotion, learning, policy dialogue, and programme collaboration. A cooperative alliance should aim at strengthening national action while promoting political commitment, within countries and internationally, to enable all to benefit from the global public good of better management of HRH knowledge, labour markets, and fiscal policies.



The goal of a stakeholder alliance is to advance global health equity through overcoming work-force constraints and capitalizing on the power of workers to accelerate health progress. A platform would not be a new, independent global entity, but rather the consolidation of actors already working together in support of country and regional activities – filling in obvious gaps in the global institutional architecture. The platform would be the political articulation of global commitment to address an issue which is, in part, the product of global labour market failures. The political imperative is to ensure that stated commitments to ensure that globalization works for the poor are translated into effective action. The alliance is the network of actors who will support and take forward this political priority.

The alliance should be a mission-driven, 10-year time-limited partnership of key stakeholders aimed at strengthening health systems and priority programmes. Guided by a small group of leaders, the alliance would be operationalized by an agile staff hosted in an existing organization. The alliance would be open to and inclusive of major stakeholders – governments, academia, educational institutions, NGOs, and professional bodies. Its primary functions should be global promotion and learning and catalytic seed support to countries through small grants linked to technical support. More specific activities would include fact finding, sharing of information and knowledge, advocacy, coordination, monitoring and evaluation, and support to country work. All these activities would aim to strengthen systems development, harmonization, and aid effectiveness. Acting as a broker and catalyst, the alliance will not build itself but rather strengthen the capacity of its membership. Ad hoc task forces, situated in membership bases, will be mandated to tackle key challenges like international migration, fiscal space, and knowledge priorities.

## 5. Launching the vision and mission

Of the several themes addressed by the High-Level Forum, few have been as consistently and energetically vetted and supported as the crisis in HRH. Growing activities, demand, and momentum from

the countries themselves escalating upwards to the regions and globally underscore the unique “window of opportunity” for timely, coherent, and effective action now. Driven by country-led and country-based processes, global and regional reinforcement can help realize the vision of universal access to essential services where every person – irrespective of nationality, race, gender, income, religion, and ethnicity – has access to a motivated, skilled, supported health worker who is equipped to help people to realize their full health potential.

The stakeholder alliance will be part of a global plan of action embedded in a global social movement on HRH. Crystallized in the World Health Report 2006 on HRH (complemented by World Health Day and the World Health Assembly of 2006), a decade of sustained action on HRH to strengthen health systems and global initiatives will be necessary to move the vision to reality.

In pursuit of the vision and mission a global plan of action is now in place comprising a series of specific deliverables and targets over the coming 1-2 years<sup>1</sup>:

- At least a dozen countries with sound national strategic HRH plans under implementation and harmonized with stakeholders and allied activities.
- Global focal point for information, knowledge, exchange and sharing of lessons learned.
- Open global forum, probably biennially, for all HRH stakeholders to report on progress, share lessons, strengthen cooperation, and create a community of HRH practice.
- Promotion and advocacy to ensure that HRH retains high political visibility and funding priority.
- Networking and promotion of engagement among southern and northern leaders in some key domains like medical migration and fiscal space.
- Mobilizing around the global platform, as the basis for harmonized international action to energize the World Health Report 2006 and champion an agenda for an HRH decade of action 2006-2015.



## Human resources developments in WHO/African region in 2004 and 2005

### Highlights of achievements

Activity	Countries - Institutions	Outcomes
Supported development of situation analysis on HRH Development of motivation and incentive plan	Burkina Faso	Situation analysis Plan available Incentive and motivation plan available
Supported in depth situation analysis for HRH and development of an emergency plan for HRH	Botswana	Situation analysis plan available Emergency HRH plan available
Situation analysis of HRH Finalization and adoption of its HRH policy and plan	Cape Verde	Situation analysis plan available HRH policy and plan available
Development of HRH plan	Central Africa Republic	HRH plan available
Supported external evaluation of college of medicine	Chad	Report available
Pedagogic training of trainers of faculty of nursing and midwifery	Comoros0000000	Reports available
Pedagogic training of trainers of faculty of health sciences	CONGO (Brazzaville)	Trainers more able to design and implant training sessions
Situation analysis on HRH	Ethiopia	Situation analysis plan available
Supported two nursing and midwifery leaders in how to conduct internal and external evaluations of nursing and midwifery training and programmes in order to improve maternal and child health	Guinea	Collaborative activity with JHPIEGO and Division of Reproductive and Family Health and is ongoing
Supported two nursing and midwifery leaders in how to conduct internal and external evaluations of nursing and midwifery training and programmes in order to improve maternal and child health	Gambia	Collaborative activity with JHPIEGO and Division of Reproductive and Family Health and is ongoing
Reviewed nursing and midwifery training and programmes Supported one nursing and midwifery leader in how to conduct internal and external evaluations of nursing and midwifery training and programmes in order to improve maternal and child health	Ghana	Report available Collaborative activity with JHPIEGO and Division of Reproductive and Family Health and is ongoing
Supported two nursing and midwifery leaders in how to conduct internal and external evaluations of nursing and midwifery training and programmes in order to improve maternal and child health	Liberia	Collaborative activity with JHPIEGO and Division of Reproductive and Family Health and is ongoing
Supported situation analysis of HRH Review of pre-service nursing and midwifery; medical and health sciences training and programmes Documentation of promising practice in community-oriented curriculum for medical education Supported three nursing and midwifery leaders in how to conduct internal and external evaluations of nursing and midwifery training and programmes in order to improve maternal and child health	Malawi	Situation analysis reports available Evaluation reports available Report available Collaborative activity with JHPIEGO and Division of Reproductive and Family Health and is ongoing
Supported situation analysis of HRH	Mali	Situation analysis report available
Supported situation analysis of HRH	Mauritania	Situation analysis report available
Supported in designing the HRH system	Mauritius	Part of the reform process which are ongoing in the country
Supported drafting of HRH plan	Mozambique	HRH draft plan available

Documented innovative approaches and promising practices in management of health workforce	Namibia	Collaborative activity with SARA and Capacity Building projects. Report available
Supported situation analysis of HRH	Niger	Situation analysis report available
Supported two nursing and midwifery leaders in how to conduct internal and external evaluations of nursing and midwifery training and programmes in order to improve maternal and child health	Nigeria	Collaborative activity with JHPIEGO and Division of Reproductive and Family Health and is ongoing
Trained nurses and midwives in pedagogics Trained post graduate students in anaesthesiology Reviewed one nursing and midwifery training and programme in Kigali	Rwanda	Reports available
Supported two nursing and midwifery leaders in how to conduct internal and external evaluations of nursing and midwifery training and programmes	Sierra Leone	Activity ongoing
Reviewed nursing and midwifery training and programme of one institution (Kwazulu Natal)	South Africa	Draft report available
Situation analysis of HRH and development of a draft HRH Policy	Swaziland	Documents available in Swaziland
Drafting of HRH plan Reviewed one nursing and midwifery training and programmes (Muhimbili) Documented promising practices on utilization of Assistant Medical Officers and Clinical Officers Supported three nursing and midwifery leaders in how to conduct internal and external evaluations of nursing and midwifery training and programmes	Tanzania	Data available for reforms
Documented promising practices on reversing the internal migration of health workers from private to public sector	Uganda	Report available
Supported to propose a new structure of HRH department and some follow-up steps to reviewing the HRH policy and strategy	Zimbabwe	Report available
Collection of data on HRH	From all 46 Member States	To assist countries with evidence based decision-making on HRH and to contribute towards establishment of HRH Observatory

#### **Additional activities not country specific**

Development of Strategy paper in collaboration with HQ on HRH crisis in Africa for the Second High-Level Forum (HLF) for the Millennium Development Goals (MGDs) in 2004 which discussed the critical shortage of HRH and urged for rapid action to address the crisis		
AFRO actively participated in the HRH Global Consultation in Oslo in February 2005 which endorsed the need for coherent response to the HRH crisis among other things		Reports available
AFRO organized and implemented AFRO/HQ Internal Consultation Meeting in Brazzaville, Congo from 21-31 March 2005 as a follow-up to the above meetings. The aim of the meeting was to explore ways of taking the HRH agenda forward in the African region and to agree on a joint plan of work with HQ		Report available

Regional Consultative Meeting jointly hosted by WHO, New Partnership for African Development (NEPAD) and ACOSHED in Brazzaville in July 2005 to discuss appropriate ways and means to increase collaboration and harmonize support to countries so as to facilitate the development of HRH at country level		Report available
A Consultative Meeting for deans of colleges of medicine from 33 countries was organized in Brazzaville, Congo from 27-30 September 2005 to discuss ways of strengthening the role of colleges of medicine in production of health workers in the WHO African region		Draft report available
Advocacy activities on migration of health workers. Focus in this area has been on a number of advocacy activities through making a case in a number of international (Geneva, June 2004) and Regional Global Commission of International Migration (February 2005) and the contribution to the AU Migration Policy Framework document in April 2004. Members States were briefed through progress reports presented at the World Health Assembly in Geneva (May 2005) and the Regional Committee Meeting in Maputo (August 2005). Joint activities with HQ, IOM on monitoring the trends on migration of health workers and interactions with the Diaspora organizations (Cape Verde, Guinea Bissau) are ongoing.		Relevant documents available









# HEALTH IN FRAGILE STATES: AN OVERVIEW NOTE

By Andrew Cassels, Paris, November 2005

## 1. Introduction

Progress in achieving the Millennium Development Goals (MDGs) requires that more attention be paid to the situation of countries in which – often, but not exclusively, as a result of prolonged conflict – governments cannot, or will not provide the stewardship needed to ensure equitable access to the essential services needed to help people survive risks to their health.

Circumstances in such countries, and therefore definitions and terminology, vary. The dynamic between stability and conflict is in itself, fragile. Nevertheless, these countries tend to receive less aid per capita (40% by some definitions) than other low-income states. Moreover, aid is more volatile, more fragmented and more poorly coordinated; compounding the difficulties of overcoming their serious development challenges.

Supporting these countries is difficult: it is costly, and is regarded by potential donors as very high risk. However, the costs of doing nothing or indeed of failing to be effective, in both human and security terms are rapidly being realized. The issue of development – and especially health development – in “fragile states” is thus gaining political prominence.

Fragile states can be characterised as those countries where there is a lack of political commitment and/or weak capacity to develop and implement pro-poor policies, suffering from violent conflict and/or weak governance.

Around 50 states can be defined as “fragile”.

Blueprints in these situations are of little use. At the same time, not everything can be dependent on context. All those involved – but particularly donors – need the confidence provided by some form of guidance which at a minimum outlines some of the choices they will inevitably face. In this respect, there are some lessons that can be learnt from experience – albeit lessons that will still require careful judgement in their application.

This note proposes a broad framework to be applied by all those working to improve health out-

comes – whether they are groups within the country concerned or outside actors. It is intended as a precursor to the development of more comprehensive guidance.

## 2. Background

The HLF in Abuja recognized that “*lack of progress in health in fragile states is undermining global progress on the health, and non-health Millennium Development Goals*” and that it is essential to “*find more effective ways of achieving the health MDGs in these countries*”.

While much of the focus of work in the interim has been on post-conflict societies, there remains a concern for those countries which, although stable, have governments which are failing to make progress in relation to their obligation to provide essential services, particularly for poor people.

As in other aspects of the HLF agenda – notably fiscal space and aid effectiveness – many of the issues are **not** specific to health. However, in all these cases, a focus on health emerges as being fruitful. Health provides a way of testing and putting into practice generic principles (such as the *Principles for Good International Engagement in Fragile States* – see below). Moreover, health is a necessity and likely to be seen as a priority, irrespective of other political differences. There is indeed some evidence that progress made in health – in new states like Timor-Leste – provides an example of what is possible in other sectors. Lastly, ensuring better health outcomes which depends on several levels of service provision and influences outside of direct health care provision, merits more detailed consideration in its own right.

To ensure synergy between different international processes, the work commissioned by the HLF has fed into the work-stream on Service Delivery of the OECD/DAC Fragile States Group (FSG), which is currently engaged in looking at better ways of supporting service delivery in health, security and justice, water supply and education.

Fragile states account for:

- $\frac{1}{3}$  of the people living in absolute poverty
- 60% of disease epidemics
- $\frac{1}{3}$  of maternal deaths
- $\frac{1}{3}$  of people living with HIV/AIDS in developing countries
- $\frac{1}{2}$  of children dying before 5
- $\frac{1}{3}$  of those without safe drinking water
- 1 in 3 of their population is malnourished
- A malarial death rate 13 x higher than other developing countries

### 3. Principles for good international engagement

In January 2005, a major conference on fragile states, sponsored by DFID, DAC, UNDP and the World Bank, produced a strong consensus around the *Principles for Good International Engagement in Fragile States*.

The principles include:

- taking context as the starting point
- moving from reaction to prevention
- focusing on state-building as the central objective
- aligning with local priorities and/or systems
- recognizing the political-security-development nexus
- promoting coherence between government agencies
- agreeing on practical coordination mechanisms between international actors
- avoiding activities that undermine national institution-building: do no harm
- mixing and sequencing aid instruments to fit the context
- acting fast . . .
- . . . but staying engaged long enough to give success a chance
- avoiding pockets of exclusion: aid orphans.

Under the umbrella of the OECD/DAC (FSG), these principles are used as a framework for action and currently being piloted in a number of countries<sup>1</sup>. The full text is provided at Annex 1.

### 4. Health care in fragile states: managing competing objectives

Broadly speaking the rationale for greater and more coherent investment in fragile states rests in the potential pay-offs in terms of better individual and community livelihoods and the global (or regional)

public good of greater security. Moreover, there is no doubt that lack of progress in fragile states will affect progress towards the health MDGs at the global level.

Whatever the specific national circumstances, interventions in fragile states will have two objectives: **addressing basic health needs and building more lasting institutions.**

- In the immediate post-conflict situation, the threats to life and health will be immediate and the challenge will be to keep health, humanitarian and development action at the heart of peace and transition programmes.
- In more stable situations, addressing basic needs may focus on achieving specific health outcomes – such as immunity to vaccine-preventable diseases. Such programmes, vigorously pursued through separate vertical programmes, can however undermine the establishment of a more broad-based and sustainable health system capable of addressing a range of health needs.
- Building stable systems for governance is essential as an end in its own right and a major contribution to overall state-building. Without oversight capacity in the health system, key institutions will remain weak and outcomes will not be delivered equitably. At the same time, building effective institutions takes time, energy and patience.
- In the meantime, civil society, with the support of outsiders, will continue to play a key role – not just in provision, but also in co-ordination and in political action, by standing up for the rights of disempowered groups in society, for example. Investment which builds the capacity of civil society therefore also has a prominent place in overall strategy.
- While state-building remains the lynch pin of much post-conflict work, it is important to remember that there are several states – referred to somewhat misleadingly as “fragile” – where a stable ruling elite constitutes a major impediment to development. Investment in civil society groups may be the only viable option for external agencies in these circumstances.

The key point then is that in most fragile states, there will be a continuing dynamic between reducing immediate vulnerability; achieving specific health outcomes; building a more lasting and equitable health system; and building the capacity of civil society.

Rapid progress in one area will usually mean trade-offs in another. Health sector development and humanitarian issues may take a back seat in the face of military and political initiatives to secure peace and stability. Many individual organizations are set up to champion and pursue particular directions – working with civil society or mounting primary health care outreach programmes, for example. Others will focus more on longer-term capacity-building. Negotiating a balance takes place in an unstable environment, where lack of trust, long-standing grievances and where the potential for destructive behaviour is at its greatest.

## 5. The importance of context: incentives and intelligence

The background paper prepared for the HLF synthesizes experience from many countries. One theme dominates the analysis: the importance of knowing the context and understanding the incentives facing all parties.

Conflict breeds lack of trust, lack of long-term vision and short-term decision-making. In many post-conflict situations, former enemies are required to work with each other. Even in stable but difficult aid environments, where it is hard to access the political space needed to engage higher levels of governments, understanding what might persuade key figures to invest in health is critical.

Understanding the incentives facing donors is equally important. Their constituencies may be suspicious in settings where checks and balances on spending are weak or non-existent, as is the case in many post-conflict environments. Even where systems are in place, domestic political opinion in donor countries about the nature of some governments may influence the availability of humanitarian versus development aid. On the other side of the coin, donors that are prepared to invest in fragile communities may be less preoccupied with measuring impact and seeking attribution.

True understanding is likely to come from the merging of many pieces of knowledge held by a broad range of actors. While it is necessary to start with a rough and ready situation analysis, the process of identifying key problems and constraints and intelligence gathering, will necessarily be iterative. Given the importance of building or rebuilding stewardship and governance functions, a careful analysis of institutional capacity is particularly important.

## 6. Alignment is a pre-requisite for success, but not easily achieved

It is usually the case in post-conflict situations that no one actor has the power to force alignment or to require that different actors harmonize their operations. Leadership always needs to be negotiated and earned. Coordination is time intensive; “meeting fatigue” and frustration are almost inevitable. Mistrust between the many actors is deep seated, and incentives to bypass coordination structures are high.

Nevertheless, some form of coalition to establish basic agreement on what can and should be done is essential. Thus while the transaction costs of establishing and sustaining coordination mechanisms may be high, the price of not doing so – in terms of wasted resources and ultimately human lives – is much greater.

In the more stable, non-post-conflict fragile-state environment, alignment poses its own challenges. If the established government is reluctant to engage on issues relating to health and poverty reduction, alternative coordination mechanisms may be needed. The structure set up by the UN, in collaboration with a range of partners, to address HIV/AIDS, TB and malaria in Myanmar is one such example.

In both sets of circumstances, planning for better health outcomes needs to be underpinned by negotiated agreements designed to standardize operations. The idea of “shadow alignment” – using structures, institutions or systems that are compatible with the existing or potential organization of the state – is common to the relief and development effort in general. Agreement on essential drug lists, treatment guidelines and planning criteria for investment in the health care network are examples of ways in which shadow alignment should operate for health, in the absence of standards determined by the state.

## 7. Inclusive planning instruments

Planning for the health sector – particularly in post-conflict environments – cannot take place in isolation. It must take into account the interaction with other aspects of development. Equally, it must recognize the legitimacy of different strategic objectives: longer-term institution-building as well as meeting immediate health needs. Actions to address the latter must be designed with care so as not to undermine longer term efforts.

Recent experience argues that a planning matrix for health should be an integral part of comprehen-

sive planning, embedded within an overall Transitional Result Matrix. The advantage of these instruments is to force consideration of synergy and interaction and, in addition, to specify results within an overall development strategy, but within a relatively short time horizon.

## 8. Strategic choices in the health sector

Having considered process and instruments, it is useful to outline some of the key strategic choices to be made in the health sector. The focus in this section is very much on post-conflict environments.

The background paper sets out a comprehensive synthesis of experience. In essence, the need is to identify and prioritize constraints: what needs to be done now? What would be better left till later? What are the costs and benefits of delays? What changes now would help underpin peace?

In this process, it is essential that constraints are analysed in terms of:

- those that existed pre-conflict – where solutions must take into account forces that created problems resulting in inequity or inefficiency in the first place. Failure to at least try to correct systemic distortions may mean that other interventions fail to fulfil their potential;
- those that have their origins within the conflict or its sequelae – the difficulty of former enemies working together, returnees taking key positions, the need to demobilize former combatants, inequitable distribution of resources, etc. Solutions in this case need to be embedded in the broader process of peace building;
- those that have arisen from the destruction and disruption of health systems and services, both in terms of loss of physical assets and human resources. Solutions in this case need to utilize local knowledge of how to build up from a low base.

The basic building blocks of health system development – stewardship, human resources, health facilities, equipment and drugs, financial resources and management systems – provide an overall guide for what needs to be addressed. However, the need to gain broad support for action, including from those outside the formal health sector, is likely to mean that several other key issues will have to be negotiated. These include:

- the level of effort to be invested in outreach services (specific health impact) compared with

the need to secure safe and dependable hospitals (reducing vulnerability);

- defining an ideal basic package of interventions and services compared to an absolute minimum that can be provided within existing resource constraints;
- facilitating and encouraging spontaneous local initiatives while thinking carefully about which are genuinely amenable for replication and expansion;
- acknowledging that while the state – or in some cases a body acting in its place – has to assume responsibility for stewardship, the provision of services will fall to a variety of public, private and voluntary providers. The objective of building effective public sector institutions should not be equated with working towards exclusive public sector service provision.

Limiting the number of priorities, and setting realistic targets will be at the heart of the process. Without necessarily recommending widespread contracting between partners, careful specification of responsibilities will be a key part of building effective working relationships. Maintaining coalitions and sustaining peace may sometimes require that it will be necessary to accept second, third or fourth best solutions.

## 9. The importance of sustainable finance

If it is hard to get stable governments to scale up in the face of unpredictable aid, it will be even harder to persuade fragile governments to do so. All the arguments raised on the issue of fiscal space therefore apply here. In addition, given the difficulties of making long-term commitments and the perceived risks of investment in fragile states experienced by bilateral donors, there is a key role for institutions such as the European Commission and the World Bank.

Two other issues in relation to the quantum of financing for health in fragile states need to be highlighted.

- Simultaneously addressing humanitarian and development needs in countries in transition is expensive because of the additional cost of reconstruction on top of the basic cost of maintaining an effective health care service. Recognizing total potential cost does not preclude sequencing aid in line with the development of the systems needed to absorb and use it effectively.



- Current evidence suggests that many fragile states fall within the group of “aid orphans” – those countries that are relatively neglected by the international community. Moreover, aid allocations swayed by geopolitical and media concerns result in financial allocation having little relationship with population needs. External aid for health care in countries emerging from conflict varies between US\$ 60 per capita per year in Kosovo, US\$ 36 in Timor-Leste and less than US\$ 3 in the Democratic Republic of Congo.

## 10. The humanitarian-development funding dichotomy

The intention of humanitarian aid – funding for people-focused survival and basic needs programmes, is highly desirable. Rapid access to funds without a prolonged process of appraisal is also critical. The short time-scale (six months or one year) makes sense from the “do not let the emergency drag on” viewpoint. However, an exclusive focus on humanitarian funding fails to take into account the reality that in many countries humanitarian needs continue for a much longer period because the political and institutional environment for development does not materialize. It is equally the case that development processes (often under way before the outbreak of conflict) need to be reinvigorated and financed as soon as possible – not awaiting a discrete development phase commencing only after the completion of humanitarian work.

The dichotomy not only represents a failure to recognize the realities of fragile states, it also has practical consequences in creating a funding hiatus for organizations that work across the spectrum of humanitarian and development activities. In terms of the objectives outlined in point 3 above, it is also likely that a reliance on humanitarian funding will favour funding for short-term results over institution building.

The need for instruments that will more effectively link humanitarian relief with development is a longstanding issue. However, it is one where action by key agencies could make a significant difference.

## 11. Points for further consideration

### a. The case for investment in fragile states

Despite a growing recognition of the humanitarian and security benefits of working more effectively both in post-conflict and other difficult environments, investment in fragile states is still perceived by

many donors to be politically and financially risky. The health sector, including HIV and AIDS, is an important entry point in some fragile states because of the spill-over effects of disease epidemics. An exploration into what opportunities exist for more sustained investment in health sector interventions in fragile states is warranted.

### b. Coordination and harmonization

Donor harmonization is a particular challenge in fragile states because of the multiplicity of global funding instruments and multilateral and bilateral actors in the sector. Sector-wide and systems-building approaches are therefore much more difficult to implement.

### c. Alignment

In a number of fragile states, bilateral agencies cannot align behind government priorities because the state is an unwilling partner in poverty reduction. In these circumstances it may be necessary for stewardship of the health sector to reside outside the state. The limitations of stewardship outside the state, the comparative advantage of different multilateral agencies to fulfil this function, and the appropriate frameworks for operating at the sectoral level require further analysis.

### d. Predictable financing for health in fragile states

Most fragile states are under-aided. Moreover, the aid they do receive tends to be highly volatile. One of the major challenges is to find ways to fund recurrent expenditure for health workers in order to decrease the costs of accessing health care for the poor. It will be important to relate the ongoing work on predictability to fragile states, and to consider what instruments exist for supporting health in the medium to long term.

### e. Managing the humanitarian-development transition

It is evident that a number of significant problems arise from the way that the transition from relief to development is currently financed and managed. While there are significant advantages in maintaining rapidly accessed, short-term humanitarian funds, a new series of bridging instruments explicitly designed for the tough job of supporting transition from conflict into recovery are needed. This proposal has broader relevance, but the need for simultaneous work on relief and development is particularly acute in health.

## **Annex I**

### **Principles for good international engagement in fragile states**

The long-term vision for international engagement in fragile states is to help national reformers to build legitimate, effective and resilient state institutions. Realization of this objective requires taking account of and acting according to the following principles:

#### **1. Take context as the starting point**

All fragile states require sustained international engagement, but analysis and action must be calibrated to particular country circumstances. It is particularly important to recognize different constraints of capacity and political will and the different needs of: (i) countries recovering from conflict, political crisis or poor governance; (ii) those facing declining governance environments, and; (iii) those where the state has partially or wholly collapsed. Sound political analysis is needed to adapt international responses to country context, above and beyond quantitative indicators of conflict, governance or institutional strength.

#### **2. Move from reaction to prevention**

Action today can reduce the risk of future outbreaks of conflict and other types of crises, and contribute to long-term global development and security. A shift from reaction to prevention should include sharing risk analyses; acting rapidly where risk is high; looking beyond quick-fix solutions to address the root causes of state fragility; strengthening the capacity of regional organizations to prevent and resolve conflicts; and helping fragile states themselves to establish resilient institutions which can withstand political and economic pressures.

#### **3. Focus on state-building as the central objective**

States are fragile when governments and state structures lack capacity – or in some cases, political will – to deliver public safety and security, good governance and poverty reduction to their citizens. The long-term vision for international engagement in these situations must focus on supporting viable sovereign states. State-building rests on three pillars: the capacity of state structures to perform core functions; their legitimacy and accountability; and ability to provide an enabling environment for strong economic performance to generate incomes, employment and domestic revenues. Demand for good governance from civil society is a vital com-

ponent of a healthy state. State-building in the most fragile countries is about depth, not breadth – international engagement should maintain a tight focus on improving governance and capacity in the most basic security, justice, economic and service delivery functions.

#### **4. Align with local priorities and/or systems**

Where governments demonstrate political will to foster their countries' development but lack capacity, international actors should fully align assistance behind government strategies. Where alignment behind government-led strategies is not possible due to particularly weak governance, international actors should nevertheless consult with a range of national stakeholders in the partner country, and seek opportunities for partial alignment at the sectoral or regional level. Another approach is to use 'shadow alignment' – which helps to build the base for fuller government ownership and alignment in the future – by ensuring that donor programs comply as far as possible with government procedures and systems. This can be done, for examples, by providing information in appropriate budget years and classifications, or by operating within existing administrative boundaries.

#### **5. Recognize the political-security-development nexus**

The political, security, economic and social spheres are interdependent: failure in one risks failure in all others. International actors should move to support national reformers in developing unified planning frameworks for political, security, humanitarian, economic and development activities at a country level. The use of simple integrated planning tools in fragile states, such as the transitional results matrix, can help set and monitor realistic priorities and improve the coherence of international support across the political, security, economic, development and humanitarian arenas.

#### **6. Promote coherence between donor government agencies**

Close links on the ground between the political, security, economic and social spheres also require policy coherence within the administration of each international actor. What is necessary is a whole of government approach, involving those responsible for security, political and economic affairs, as well as those responsible for development aid and humanitarian assistance. Recipient governments

too need to ensure coherence between different government ministries in the priorities they convey to the international community.

### **7. Agree on practical coordination mechanisms between international actors**

This can happen even in the absence of strong government leadership. In these fragile contexts, it is important to work together on upstream analysis; joint assessments; shared strategies; coordination of political engagement; multi-donor trust funds; and practical initiatives such as the establishment of joint donor offices and common reporting and financial requirements. Wherever possible, international actors should work jointly with national reformers in government and civil society to develop a shared analysis of challenges and priorities.

### **8. Do no harm**

International actors should especially seek to avoid activities which undermine national institution-building, such as bypassing national budget processes or setting high salaries for local staff which undermine recruitment and retention in national institutions. Donors should work out cost norms for local staff remuneration in consultation with government and other national stakeholders.

### **9. Mix and sequence aid instruments to fit the context**

Fragile states require a mix of aid instrument, including, in particular for countries in promising but high-risk transitions, support to recurrent financing. Instruments to provide long-term support to health, education and other basic services are needed in countries facing stalled or deteriorating governance – but careful consideration must be given to how service delivery channels are designed to avoid long-term dependence on parallel, unsustainable structures while at the same time providing sufficient scaling-up to meet urgent basic and

humanitarian needs. A vibrant civil society is important for healthy government and may also play a critical transitional role in providing services, particularly when the government lacks will and/or capacity.

### **10. Act fast . . .**

Assistance to fragile states needs to be capable of flexibility at short notice to take advantage of windows of opportunity and respond to changing conditions on the ground.

### **11. . . . but stay engaged long enough to give success a chance**

Given low capacity and the extent of the challenges facing fragile states, investments in development, diplomatic and security engagement may need to be of longer duration than in other low-income countries: capacity development in core institutions will normally require an engagement of at least ten years. Since volatility of engagement (not only aid volumes, but also diplomatic engagement and field presence) is potentially destabilizing for fragile states, international actors commit to improving aid predictability in these countries by developing a system of mutual consultation and coordination prior to a significant reduction in programming.

### **12. Avoid pockets of exclusion**

International engagement in fragile states needs to address the problems of “aid orphans” – states where there are no significant political barriers to engagement but few donors are now engaged and aid volumes are low. To avoid an unintentional exclusionary effect of moves by many donors to be more selective in the partner countries for their aid programmes, coordination on field presence and aid flows, and mechanisms to finance promising developments in these countries are essential.

Source: OECD, Development Co-operation Directorate, DCD (2005)8/REV2, 7 April 2005

# HEALTH SERVICE DELIVERY IN POST-CONFLICT STATES

By Enrico Pavignani, Paris, November 2005

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## 1. Introduction

The international debate on the transition from conflict to peace is thriving, both in academic and donor circles, thanks to the wealth of experience gathered from a variety of post-conflict recovery processes. The recognition that conflict and post-conflict situations will provide a significant challenge to policy-makers and field practitioners for the foreseeable future, has convinced concerned parties of the need to explore the field in depth, to document lessons learned, and to identify best practices.

At the same time, concern about the burden that such troubled contexts may place upon the worldwide campaign to achieve the Millennium Development Goals (MDGs) has grown. Donor agencies involved in such efforts recognise the importance of adopting approaches that are appropriate to post-conflict environments, which help to boost health service delivery and contribute to the achievement of the MDGs, without compromising the long-term development of health sectors recovering from severe crises.

Investment in health service development in post-conflict countries is important for several reasons. First, it helps to alleviate the suffering of large war-weary populations. Second, it contributes to consolidating the peace process. Third, it may provide huge long-term returns in terms of the equity, efficiency and effectiveness of the services provided. In sum, decision-makers have a precious opportunity, which should not be missed. Given the complexity of the process of transition from war to peace and the multiple constraints and conditions facing the actors involved, a sensible approach will need to be evolutionary, multi-faceted, context-oriented, and shaped by multiple trade-offs. As yet, no tried and trusted formula exists.

Aid agencies are committed to developing shared strategic and operational approaches, along the lines laid out in the Harmonization and Alignment agenda, to enhance the effectiveness of the support they provide. This document is part of this ongoing global effort. It reviews the principles

to be adopted in order to inform the measures that should be taken, and those that should not, to boost recovery and lay the ground for development. The knowledge accumulated as a result of work undertaken in countries such as Uganda, Mozambique, Cambodia, East Timor, Angola, Kosovo, Afghanistan, Somalia, Sudan, DR Congo and Iraq, synthesised in this paper, should help to equip parties involved in future post-conflict processes with principles and tools for action.

## 2. Post-conflict environments

Sometimes, the transition from war to peace is brought about by specific, tangible events, such as a peace agreement, or the outright military victory of one side over the other. In other cases, such as Somalia and the DR Congo, the process evolves slowly and erratically. No-war-no-peace lulls are common in post-conflict processes. The explicit features of a post-conflict transition may only emerge later.

### a. Variety of post-conflict situations

- Rebel regions break away from existing states and attain internationally-recognized independence, for example, Eritrea and East Timor. Sometimes, because of international sensitivities, new entities retain an ambiguous status, as in the case of Kosovo or Somaliland. In new states that have achieved freedom from domination by ethnic or political groups, the formulation of unrealistic development plans, perceived by both the rulers and the ruled as part of a political dispensation, is common. The provision of health services often comes under the remit of this well-meant but usually ill-fated agenda.
- The state survives within its original borders, but a new group accedes to power as an outright victor, as in Uganda, Rwanda and Afghanistan. An agenda for change stands a better chance of being formulated or adopted by new rulers eager to affirm themselves.



- The incumbent government survives the crisis and maintains its grip on the state, as in Mozambique and Angola. Its political agenda may change dramatically in the process, as observed in Mozambique. The rebels who challenged the government become the officially-recognized civilian opposition. The continuity of rulers and civil servants may facilitate the recovery of public health service provision. On the other hand, entrenched distortions, archaic administrative provisions and practices, and prevailing conservatism may jeopardise attempts to reform the sector.
- After the failure of the state, a new government, agreed upon by some parties to the conflict, tries to affirm itself with international support, like in Liberia and Somalia. Its concerns are likely to focus on security issues and the financing of basic state functions. Health services tend to receive only scant attention. Violence may peter out in parts of the country, but persist in others. The capital city and other comparatively richer areas may enter a post-conflict period, while outlying or marginal regions remain affected by endemic conflict, or suffer relapses of violence. Furthermore, parts of the country may remain under the control of parties loosely or only nominally linked to the central government.
- Complex negotiations lead to a settlement between the parties, who agree on power- and wealth-sharing provisions, as seen in Sudan and the DR Congo. This situation is one of the most challenging for donor agencies. The chances of the country relapsing to war are high. The new government, usually embroiled in a web of ambiguities and trade-offs, is indecisive and lacks coherence and credibility. Conflicting messages are commonplace. The international community may be as fragmented and inconsistent in its approach to the situation as the country itself.

**b. Decision-makers face an impressive array of difficulties, including some or all of the following:**

- A poor information base characterized by incomplete and/or contradictory data. Aggregate figures relating to resource allocation patterns are regularly lacking, incomplete or flawed. Even robust findings may be easily challenged or simply ignored by parties pushing decisions in directions at odds with them.
- Most actors suffer from a knowledge gap. Insiders (including locals and foreigners with a long-standing presence in the country) may have been confined to secure enclaves, and thus be ignorant of the conditions prevailing in large areas of the country. They are likely to be unaware of the lessons learned in previous post-conflict processes. Many insiders remain on the fringes of the aid system. Truly knowledgeable people may be sidelined because of their political allegiances, or because of language barriers. Health care delivery systems segregated from each other are often blind to developments taking place across the frontline(s), as recently witnessed in Sudan.
- At the other end of the spectrum, newcomers may be ignorant of the context, language, culture and history of the country in transition. In addition, they are often unaware of promising initiatives developed at the local level in response to the disruption wrought by war. True understanding is likely to come from an amalgamation of the many pieces of knowledge held by a broad range of actors.
- A low absorption capacity, due to weak or absent institutions, poor communications, a dilapidated skill pool, and crippled or abandoned management systems. Corruption is often rampant. If the collapse has involved also the private sector, the absence of banks, auditing firms, civil works contractors represents an additional, severe constraint.
- An uncertain financial, political and administrative future. The future fiscal position of the recovering state, particularly a newly emerging one, is usually unclear. Diverging or conflicting policy statements from incumbent, transitional, or shadow authorities are common. Commitments to the provision of social services by governments in charge of countries moving from war to peace tend to evolve over time, according to survival imperatives and political expedience. Social services are unlikely to rank high on the agenda of rulers unsure of their tenure, but may be presented as priorities by governments eager to win international recognition and secure financial support. Health tends to represent a minor concern for governments, while remaining a favourite with donors.
- Uncertain future external support. Aid is usually allocated by donors on a very uneven basis (see the table below), and fluctuates considerably over time. Geopolitical concerns and media coverage play a preponderant role in influencing



## External aid allocated to health care in transitional countries

Country	Year	Amount per head	Source
Cambodia	1994	\$2	Lanjouw <i>et al.</i> , 1999
Mozambique	1995	\$5	Ministry of Health, 1997
East Timor	2000	\$36	Tulloch <i>et al.</i> , 2003
Kosovo	2001	\$60	
Southern Sudan	2003	\$7	Health Secretariat of the New Sudan, 2004
Somalia	2003	\$5	Somalia Aid Coordination Body, 2003
RD Congo	2005	\$2 – 3	Banque Mondiale, 2005

aid allocations. Furthermore allocations of similar aggregate magnitudes are often given to countries with very different population sizes. Additionally, decisions about aid allocation are often the result of opaque competition among recipient candidates. Favourite countries get the lion's share, at the expense of the others. Even within countries, certain sectors and geographical areas are privileged. The presence of aid intermediaries, such as NGOs and charities, may play an important role in channelling aid to certain countries, sectors and areas.

- Peace-building taking precedence over other competing concerns. Expectations in relation to peace dividends may fail to take into account the heavy cost of peace-building, as witnessed in Southern Sudan in 2003-4 (Health Secretariat of the New Sudan, 2004). The peace process may require the integration of previously partitioned or hostile parts of state administration, and of the respective health services. This usually bears heavy opportunity costs. Peace-building imperatives may create distortions that are unmanageable in the long-term. For example, after the ceasefire in Angola in 2002, an already bloated health workforce expanded further to incorporate UNITA health workers.
- Fears of relapse to war, which discourage long-term initiatives. Diffidence across the conflict divide(s) is likely to permeate most indigenous decisions, and to colour the interpretation of actions and events. Even well-intentioned donor moves may be seen as partisan by distrustful parties.
- Diverging or conflicting agendas of powerful players. Tensions among parties, be they humanitarian, political, military or development actors, are commonplace. In the politically-charged and often ideology-laden context of a post-con-

flict recovery process, partisan manipulation of most decisions is common.

- Urgent needs to be addressed, which are often more severe than those anticipated during war-time. The need to deal with previously inaccessible destitute populations, epidemics, or mass resettlements may become so pressing as to take precedence over long-term recovery concerns.

### c. Post-conflict transitions may also present positive features:

- A wave of enthusiasm and renewed energy, particularly when the outcome of the conflict is clear and popular among large sectors of the population. Rapid economic growth is often triggered by post-conflict processes. Regrettably, peace processes, population movements and economic booms can also provide a fertile soil for the spread of disease.
- More favourable international relationships, sometimes accompanied by high levels of direct foreign investment, such as in Mozambique in the 1990s (Pavignani and Colombo, 2001). This shift depends to a large extent on the political alignment of the recovering country, on the macroeconomic performance of the post-conflict government, and on its capacity to interact with donors.
- Expanded aid flows, directed to support the peace process and the ensuing reconstruction. However, donor pledges are not always followed up by corresponding aid allocations, particularly in marginal countries. Expectations of expanded aid flows should be always submitted to reality checks. Unfortunately, tracking aid flows is always challenging. Available inventories may be not be adequate enough to provide guidance to decision-makers. Only sustained expert efforts are likely to yield reliable results.

- The establishment of a legitimate government, endowed with political capital, and willing to introduce true reforms. The ability of such governments to deliver on political promises may however fall short of expectations. The capacity of state institutions to play their role is usually poor or unknown. This is likely to change over time, as institutions recover or are built anew, and officials learn their business. Capacity emerges unevenly, with some sectors and bodies being stronger than others.
- The return of people, skills and resources, displaced abroad during the conflict. Whereas destitute refugees may choose to return home as soon as minimal security conditions allow, a wealthy diaspora is likely to wait until domestic living standards and business opportunities have improved significantly. High expectations about the contribution of the diaspora to the recovery of a war-torn country have gone unfulfilled in several occasions.

### 3. Characteristics of health sectors in states emerging from protracted crises

A common mistake is to assume that most or all of the shortcomings of the health sector emerging from protracted conflict have been caused directly or indirectly by it. Insiders are particularly vulnerable to this misinterpretation. In fact, many of the weaknesses observed in post-conflict health sectors pre-date the crisis. A review of the pre-war situation may reveal conditions similar to those found in other fragile states. For instance, resources were insufficient to operate oversized health networks, dominated by tertiary urban hospitals. External dependency increased as internal financing declined, due to economic crisis and to growing security expenses. The workforce was under-skilled and distorted in its structure. Operational inefficiencies were severe. Ineffective, top-down, and authoritarian management systems were common. Only a limited portion of the population had access to any health services, and these were inappropriate in their content and of questionable quality.

In most cases, the conflict serves to exacerbate the problems of an already fragile health sector. Scarce resources contract further, or are redirected towards security and logistic expenses. Dependence on external sources of funding increases, sometimes becoming absolute. Aid inflows oscillate wildly and unpredictably, with severe consequences for health service delivery. Humanitarian aid expands, at the

expense of development funding. Policy formulation becomes fragmented, detached from reality and inconclusive.

The health care network contracts and decays, while the urban and hospital biases grow. First-referral hospitals in rural areas suffer badly from direct violence, under-funding and neglect. Management systems weaken and in some cases collapse. Special programmes expand, to become the main vehicles of health service delivery. Inefficiencies grow, while gaps and duplication in allocation worsen. Coverage shrinks. Health services become commodities, affordable only by the wealthier sectors of the population.

In some cases (Cambodia, East Timor), the workforce contracts; in other situations (Angola, Sudan), it expands, through the enrolment of many lesser-skilled workers. Health workers concentrate in secure areas (either in the country or abroad). Training standards are invariably eroded. Protracted periods of violence severely affect the skills of the workforce, which emerges from the crisis in very poor shape, and in need of a prolonged rehabilitation programme (Smith, 2005).

Recognizing that some of these problems pre-date the conflict may help to identify appropriate post-conflict corrective measures. In Angola, the urban and hospital bias was aggravated, but not created by the war. It remains a dominant feature of that health sector, years after the end of hostilities.

Health sectors respond to crisis in many ways. Health service delivery fragments geographically and along vertical lines. Because of external funding, easy access and better security conditions, islands of relative privilege emerge amid widespread deprivation. Thanks to the presence of humanitarian actors, areas affected by violence may be better served than other, comparatively peaceful ones. This was the situation in the DR Congo in 2005, where health indicators gathered in the Equateur region, which had been largely spared from the war, were among the poorest in the country. By that same token, refugees may have access to better health services than people who remain in country, or host communities. Different systems of health care provision may develop in partitioned settings. To get an accurate picture of how the health sector responds to crises, an analysis needs to highlight such differences rather than bury them in national averages.

Health care provision becomes deregulated, privatised (formally and informally) and commoditised. Quality of care tends to decline even further. The

share of health financing borne by households increases, particularly in those countries unable to attract considerable donor support, like Somalia and the DR Congo. A gap opens up between private health expenditure, which can become substantial, and purchased care, which is usually poor, and often dangerous. Inefficiencies grow further. Operational costs skyrocket, in part also because of security concerns. Actors multiply; crisis management prevails; action takes precedence over understanding.

Although the adaptive responses to crisis outlined above may contribute to the short-term survival of the health sector, their long-term consequences are often serious. Adaptive responses tend to occur at the micro level, go undetected and only be partially understood. They may only become apparent with hindsight, when it is too late to act upon them. Entrenched distortions do not heal spontaneously, nor can they be easily reversed once the crisis is over. They have to be addressed pro-actively and from a long-term perspective.

In summary, health services emerging from protracted periods of violence are inefficient, ineffective and inequitable. Without sustained and thorough intelligence work, the contours of the main problems may remain unrecognized. Policy discussions may focus on marginal issues or on rumours, which are repeated so often in the absence of supporting evidence, that they eventually come to be accepted as facts.

Although many of these patterns can be observed in fragile but stable countries too, the intensity with which they occur differs. In a stable but weak environment, actions to palliate for such shortcomings tend to be slow and introduced incrementally, often only on the fringes of the real problems. Conversely, in a country emerging from protracted violence, certain structural issues can (under favourable conditions) be tackled directly, with drastic measures.

#### 4. Main actors on the health stage

The transition from conflict to peace typically allows for an increasing number and variety of actors to appear and to operate including:

**Official funding agencies**, who at the start of the transition process tend to act indirectly, through UN agencies and NGOs. As the recovery process moves forward, bilateral agencies and development banks assume greater visibility and direct influence.

**Informal funding agencies**, such as charities and private contributors. In some contexts, like Somalia,

the informal support received from Islamic charities and diaspora members is considered as substantial. In spite of the difficulty of tracking these resource flows, they should not be overlooked, as is often the case.

**Government (central and local authorities).** Clear leadership cannot be expected from a newly-installed, insecure government. Furthermore, local rulers may pursue policies that bear no relation to those chosen by central authorities. In some cases, after a lengthy absence, exiles return to take up senior positions in a new government. Some exiles, who have lost touch with the domestic developments that have taken place during the conflict, may favour inappropriate approaches.

**Rebels.** During conflicts, some rebel organisations may have become involved in health service delivery, and, as a result, have developed elements of a health policy to be adopted upon their accession to power. Other fighting groups, on the other hand, may not have shown any interest in social issues. In most cases, rebel health services have failed to live up to the inflated promises of wartime. Their contribution to post-conflict recovery has frequently been marginal. Rebel parties may be given junior government posts, like that of Minister of Health, as part of the peace deal.

**UN agencies.** In transitional contexts, these agencies enjoy several comparative advantages, including a long-term presence in the country, a technical mandate, and a relative distance from geopolitical and economic interests. On the other hand, UN agencies have often struggled to fulfil their potential. Among the reasons for this, under-funding and related fund-raising concerns, lack of flexibility at country level, cumbersome procedures, shortages of skilled staff and rivalries within the UN system, stand out as the most obvious.

**International transitional authorities and peace-keepers.** Sometimes these provisional bodies are given specific health mandates.

**Military, indigenous and foreign armies.** These affect health care provision in several ways. Armies control the access of health service providers to contested areas and to populations in need. The distribution of health services is therefore highly dependent on military decisions. Also, they provide health services to their personnel, services which are often made accessible to civilians. During the transition from war to peace, army health workers may be discharged

from service, thus entering the civilian health care job market.

**NGOs, international and local.** The importance of NGOs in delivering health services cannot be over-emphasized. They represent a precious asset, to be fully exploited, as well as regulated, during the post-conflict transition process. A wealth of mainly unstructured knowledge and experience (written and oral) is usually scattered across the NGO community, waiting to be tapped. Sometimes, NGOs have already developed and put in place innovative interventions of potential interest for the whole sector, though these are not always recognized. Before importing blueprinted models from abroad, these native experiences should be assessed and supported. Protracted crises characterized by a large NGO presence, like Afghanistan, Somalia or the DR Congo, should be seen as testing grounds for health service provision. During periods of post-conflict transition the strategic and operational autonomy of NGOs is likely to shrink, as indigenous health authorities try to impose their presence and will on health actors. In this endeavour, they often find powerful allies in important financiers willing to engage in the health field. The risk here is that although NGOs may maintain their role as health service providers, the policy discussion develops far from them.

**Special programmes,** which in many cases are responsible for a large portion of health service delivery. They are usually managed and supported by technical professionals tied to MoHs, international agencies and donors in complex webs. Professionals with a long experience of vertical programmes are often competent, result-oriented and committed to delivering targeted services. They may be very influential. Usually, they are not interested in events taking place outside their remit, or in sector-wide discussions about service development and post-conflict recovery.

**Private for-profit entrepreneurs.** Their contribution to the delivery of health services usually gains in importance during conflicts. Formal and informal health businesses, that are very visible in large cities with affluent elites, include health care facilities, labs, training outlets and drug suppliers. Private actors are usually excluded from the formal policy debate about service delivery, despite their influence on political decisions and on field operations.

**Users of health services,** who through their decisions influence health service provision.

Depending on their respective roles, participants in post-conflict recovery processes may be confronted by many dilemmas that are not always explicitly formulated and discussed. Their choices may depend on personal or organizational preferences, on the interplay of incentives, on the desire to minimize the risks at stake, or on aid fashions, rather than on an accurate reading of the situation, and of the true options on offer.

The complexity of the situation faced by decision-makers may have a paralysing effect, particularly on insiders who are fearful of inflicting further damage on already fragile systems. Other players may decide otherwise, and rush ahead with bold decisions, perhaps linked to international agendas. A judicious, thought-through activism seems the wisest course of action between these two extremes.

## 5. Dangers and opportunities created by the transition from war to peace

The defining features of a post-conflict process are the political sensitivities that influence decisions, the opportunities for change, the rapidly evolving context, the imperative to act, and the external support apportioned to a recovering country. A variety of decisions with far-reaching consequences must be reached within a short time span. This window of opportunity tends to close as soon as the country normalises, and sometimes even earlier. Decision-makers are not allowed many second chances. Dangers and opportunities must be first recognized for what they are, and then quickly acted upon.

### a. Dangers

Health services may remain severely lacking in resources to meet the requirements presented by post-conflict recovery. This can be due to the marginal importance of a country in donor eyes, to the state's inability to raise revenues, or to the low priority given to health services by the government. As humanitarian operations come to an end and recovery-oriented financing is not available, or expands too slowly, a funding gap may open. This gap may remain undetected, because of a lack of consolidated and reliable figures about aid flows. Inadequate financing is often compounded by crippled management systems, which reduce further the amount of the funds made available to spending bodies. In the DR Congo in 2005, only a negligible share of the expanded state budget reached health service providers (World Bank, 2005).



Donors may refrain from supporting a new government that is unable to establish its authority. By doing so, they are condemning it to failure for lack of resources, and hence of credibility. In 2005, a circular argument frequently voiced among donors involved in Somalia stated that the new transitional government had to show commitment and some minimal capacity before donors would invest in it. Unsurprisingly, the new government has so far limped along, without registering much progress.

Crippled state institutions may be unable to implement chosen policies, even in the presence of genuine political will. Health authorities may lack the political clout needed to enforce unpalatable reforms. Corruption, mistrust and abuses may obstruct policy implementation. Health services may remain deregulated, heavily skewed in favour of curative care, privatised and commoditised as in wartime. During the 1990's, the Angolan MoH produced a set of promising recovery-oriented documents, which have largely failed to translate into action on the ground, because of implementation constraints.

Proliferating 'priorities', imposed by influential stakeholders, may spread capacity and resources thin, and deny direction and coherence to health service delivery. Additionally, international priorities, like the polio eradication campaign, may take precedence over indigenous ones. This situation was recently observed in Southern Sudan.

The right lesson may be applied to the wrong context, because it is erroneously considered similar to the one originating the lesson, or because of an inadequate or flawed understanding of the context. Alternatively, the wrong lesson may be retained, because of ideological biases or of a distorted analysis.

Over-ambitious investment decisions may lead to unsustainable health services. Rosy forecasts of the level of health care provision that a country will be able to afford are common. Experience suggests that over-estimating future resource levels is a more common mistake than under-estimating them. Trying to rebuild the health sector along pre-conflict lines, with a curative, high-tech orientation is an associated temptation. This flaw, first observed in post-conflict Uganda (Macrae *et al.*, 1994), is common, particularly in well-financed recovery processes, such as in Angola.

Critical events may unfold without attracting the attention of decision-makers who are too absorbed by the peace process and the ensuing recovery. In Mozambique in 1992-94, millions of refugees returned home from neighbouring countries with high HIV

prevalence. Subsequently, the infection spread rapidly within Mozambique. The gravity of the situation only became clear once it was too late to act.

## **b. Opportunities for strengthening health service delivery**

Hitherto unforeseen opportunities emerge during transition processes. Sometimes these opportunities are not even identified, let alone seized upon, for a variety of reasons, including lack of flexible funds and available capacity, competing issues, poor intelligence, organizational rigidity and aversion to risk. Situations which may give rise to valuable opportunities include:

- The collapse of an old regime and of the delivery models associated with it may encourage stakeholders to experiment with novel initiatives, like primary health care (PHC). Local cadres who have settled abroad or been employed in the country by international agencies and NGOs may have gained exposure to new ideas, approaches and delivery models, and may therefore be supportive of change.
- The joint management of donor resources may contribute to upgrading indigenous management systems, which are crucial to health service recovery. This has been seen in post-conflict Mozambique, with sector budget support (see box).
- The collapse of the public sector may usher in a new modern, lean and responsive civil service. Conversely, where the state administration has survived the crisis intact, as seen in Mozambique, reforming it has proved elusive.
- The weakening of the state apparatus may offset old authoritarian and corrupt habits, thereby paving the way for the freer circulation of information and for a participatory policy debate (as now witnessed in the DR Congo).
- Financial hardships, coupled with the collapse of old supply channels, may provide the impetus for introducing large-scale, competitive purchasing of effective, low-cost generic drugs.
- The concentration in safe areas of under-utilised health workers offers room to restructure the workforce, through a comprehensive retraining and upgrading programme. A process of this type took place in Mozambique towards the end of the war (Pavignani and Colombo, 2001).
- The massive destruction brought about by the war offers space for rationalizing the health net-



work, by downsizing tertiary hospitals (a measure usually out of the question in peacetime) and expanding first referral and PHC facilities. International support may allow investment to be directed to under-served areas.

## 6. Examples of best practice

### a. Best practice (general)

- Adopting a sector-wide appraisal of health service delivery. To “think nationally and programmatically” (Leader and Colenso, 2005), even at the height of a crisis, is paramount. Many shortcomings observed in the delivery of health services are in fact manifestations of sector-wide distortions. In DR Congo, a lively debate around cost-sharing schemes has been going on for years. No attention is being paid to present and likely future crushing levels of under-financing, which force many service providers to charge fees for services in order to stay afloat. The policy discussion would benefit from focusing on the structural obstacle of the lack of funding, and placing less onus on the side issue of cost-sharing.
- Repairing pre-existing, damaged management systems whenever possible, before or instead of rushing to introduce new ones. “. . . institutions that survive a war may be more resilient than they appear.” (McKechnie, 2003). To verify whether old management systems are viable in post-conflict settings, they have to be provided with resources, put in motion and thoroughly studied. In many instances, their strengths and weaknesses can be recognized. Some elements can be rescued and maintained after consolidation, others must be redesigned, while some flaws have to be overcome through the introduction of new tailored components.
- Building recovery plans on sound forecasts of resource and capacity constraints. The objective technical difficulty of developing realistic projections may be overcome with adequate effort. The international experience of revamping social services after protracted periods of disruption may greatly assist the planners engaged in building sustainable systems.
- Although constraints imposed by resources and capacity are interrelated, they should be assessed separately, as they call for different responses. Where adequate capacity exists, increasing levels of resources may provide substantial returns in the short-term. However, investing additional

resources in the absence of such capacity tends to encourage further waste. By that same token, if the existing resources are inadequate, capacity tends to be eroded, or inefficiently allocated. Capacity-building initiatives alone are likely to be ineffective.

- Recognising that certain structural changes caused by a deep, protracted crisis are irreversible. For instance, after decades of deregulated privatisation, a return to the public provision of most health services is probably an unrealistic option. Positive new features should be identified, rationalized and strengthened, while negative ones should be tackled with realism. Plans to go back to a remote and often idealised past should be considered with suspicion.
- ‘Aligning’, as far as feasible, procedures, systems and approaches. In most countries, where weak institutions discourage the full adoption of government systems, the ‘shadow’ alignment approach should be pursued (OECD, 2004). Its potential for rationalizing the support provided by donors justifies the costs incurred by participants in pursuing it.
- Introducing aid management tools, such as trust funds and pools, which oblige participants to harmonize their activities, early and on a manageable scale. Finding a trade-off between controlling the fiduciary risk inherent in these instruments, and setting procedures at levels that are attainable by indigenous institutions, is essential to move forward in this field.
- Establishing aid coordination mechanisms, even in the absence of a recognized central government. For example, the Somalia Aid Coordination Body (SACB) provides a forum for participants to collect and share information, respond to crises (like epidemics), negotiate joint actions, and draw up joint funding proposals. In 2005, the SACB gave the Somali transitional government valuable opportunities to participate in discussions, to understand the perceptions and goals of international players, to present their incipient policy agenda and to receive relevant feedback.

### b. Best practice (health-related)

- Starting the work on health sector recovery in advance of, and at a distance from, political developments, as done in Mozambique in 1990-91 (Pavignani and Colombo, 2001). A sound, well-known strategic framework, endorsed by credible

## Sector Budget Support to recurrent provincial health expenditure in Mozambique in the 1990s

Introduced towards the end of the war as a gap-filling measure to revive derelict health services, sector budget support evolved over time to play a major role in the service expansion that took place in the decade that followed. Supposed to flow through state financial management channels, and to be allocated according to local decision-making procedures, sector budget support initially encountered serious problems. These were caused by the decay of state management systems, the unreliable nature of the information available and questionable priority-setting habits. However, the offer of unallocated fresh funds constituted a powerful incentive for local officials to reorganise their management systems.

After a few years of hard work and thanks to the robust technical support provided to them by the donor, most provinces were able to tap these financial resources, to allocate them in meaningful ways and to account for their expenses at levels acceptable to the donor. Health service coverage expanded dramatically over the following years, and wide service imbalances were reduced. Further, the scheme forced partners to review all the resources allocated to provinces and districts, so that the available budget support could be directed to cover the most serious gaps. Operational efficiency improved significantly.

Information gathered as a result of this exercise enabled an analysis of resource and output patterns at national levels, which in turn influenced the structure of the state budget, and the allocative decisions of some donors. As a consequence, coordination improved. Other donors joined the scheme, thus providing a working model for ensuing SWAp discussions. In addition, programming and accounting practices gained by managing this budget support equipped the health sector to absorb the progressively increasing state funding.

Most of the beneficial long-term effects of the scheme were not foreseen at the time of its launch. An almost desperate initiative, introduced in the least propitious environment, contributed beyond expectations to the recovery of the health services. Key factors that explain the success of this initiative include the embedding of the arrangement into indigenous systems, its incremental growth according to recorded progress, its ability to weather the many crises it encountered, its openness to innovation and to change, a solid understanding of local conditions, and a measure of risk-taking.

actors, may foster the coherent and efficient recovery of health service, by shaping the decisions and actions of concerned parties (particularly of newcomers), when the country opens up and health services expand.

- Investing early in the systemic analysis of the health sector and health service delivery, as in the DR Congo in 2004-5 (World Bank, 2005). Continuous sector-wide analysis is more effective than one-off studies. An independent policy analysis unit should be established as soon as the environment allows.

Furthermore, health care delivery systems developed during the conflict must be studied with a view to promoting their integration. For example, in Sudan, public provision of health services is prominent in areas controlled by Khartoum. In the Southern areas, administered by the SPLM, NGOs are largely responsible for the delivery of health care. Different working languages, categories and job descriptions, training programmes, management and contracting practices, and incentives all need to be accommodated within a coherent framework. This contentious, complex and slow process needs careful stewardship. If successful, it can serve to defuse politically explosive issues and contribute positively to peace-building and reconciliation.

- Introducing measures that address deeply-rooted systemic distortions at the outset. Transitional health sectors are often characterized by a lack of funding, a bias towards tertiary hospitals and curative treatment, an under-skilled and often bloated workforce, and perverse incentives. Without correcting or at least containing these distortions, other interventions are unlikely to fulfil their potential.

For example, early investment in human resource development is a precondition for health service recovery. Training competent and appropriate professionals during wartime is likely to yield dividends after the end of hostilities, when health services need to suddenly expand to cover previously inaccessible areas.

- Introducing rational and progressive drug management systems. Devoting attention to drug procurement and distribution is important for several reasons:
  - Drugs account for a large portion of health expenditure, and for a disproportionate share of household health spending.
  - The availability of drugs boosts the credibility and hence the uptake of health services.
  - Rationalising drug procurement and distribution is possible even in fragile environments (See the box on the DR Congo).

- The process of negotiating and putting in place common drug procurement and distribution arrangements provides an excellent learning ground to practice coordination on concrete terms, and a model for restructuring other components of health care provision.
- ‘Shadow aligning’ interventions, by establishing an array of standardising instruments, such as:
  - a common salary scale, to be adopted by non-profit health sector providers, as done in Afghanistan in 2003.
  - a common policy on cost-sharing, backed by a solid cost analysis, and grounded in a realistic appraisal of its impact.
  - standard contracts for public-private partnerships, outsourcing, civil works, procurement of goods, etc.
  - an essential drugs list with treatment guidelines.
  - planning criteria for investing in the health care network. These must include details of ratios of facilities to population, standard layouts for health facilities at different levels of care, building and equipment specifications, and respective average costs.
  - job descriptions and training programmes, supported by a certification facility. In Southern Sudan in 2000-4, a personnel council, established with expert support, reviewed the categories, job descriptions and training programmes that had proliferated over the years, thanks to multiple NGO initiatives. New professional cadres were introduced. Testing and training programmes were designed to convert the qualifications of existing health workers into the new standardised categories. An innovative phased-training strategy was introduced. With the advent of peace, the challenge ahead is to boost high-quality training to respond to the needs of the recovering health care network. Most of the preparatory conceptual and technical work has already been done.
  - data collection tools, building blocks of a recovered health management information system.
  - service package(s), the costs of which have been realistically estimated. In large countries with different delivery settings, several service packages may be needed. For instance, in Somalia urban, rural-sedentary and nomadic communities require different packages. Each incurs different costs.

Given the evolving nature of post-conflict transition, such tools for standardisation must be designed quickly and introduced on an interim basis. Devoting large amounts of energy and resources to producing high-quality standards would be wasteful, precisely because of the changing environment, and even counterproductive, if it delays their introduction. What is essential is to put together guidelines (that draw on internationally-recognized standards if they already exist) and to introduce them as rapidly as possible into practice, so that their shortcomings can be identified and corrected.

- Capitalising on positive local initiatives, particularly those with potential for replication and expansion. Existing local responses must be actively studied, so as to identify those with promise from a sector-wide perspective. See the box on the drug procurement system introduced in the DR Congo.

## 7. Common mistakes to be avoided

Any engagement in a post-conflict recovery process entails an element of risk. Key to progress is that mistakes made in such an uncertain and unstable context are recognized as such, openly debated, and corrected as soon as possible, so that they are not repeated. Lessons learned from previous post-conflict transitions can help to inform decisions and minimize the potential damage done to health services.

### a. General mistakes

- Judging that nothing valuable has survived the crisis. Also, thinking that it is impossible to make sense of a chaotic environment, and therefore rushing to make decisions unsupported by understanding. Blueprints, like standard health sector reforms, are then imposed across vastly different contexts.
- Ignoring the lessons learned in previous recovery processes. Two fallacies are common currency: that each crisis and ensuing recovery is unique, and conversely, that all processes are similar. Too many stakeholders tend to under-estimate the difficulties of a recovery process, and to ask for simple solutions, which most of the times are wrong.
- Marginalising from policy discussions custodians of field knowledge, like NGOs. These organisations may end up unable to contribute as much as they could to the formulation of health policies. This flaw was evident in Afghanistan in

## Responding to the collapse of drug supply systems in the DR of Congo

The disarray caused by the failure of the state and the subsequent conflict had a severe impact on the pharmaceutical area. Drug shortages were generalized. No regulatory functions survived. In the absence of public financing, households had to pay dear for drugs of dubious quality. A variety of schemes, private or donor-supported, emerged to cope with this situation. An autonomous non-profit supply agency, established in 1993 by a group of NGOs to cover the needs of the war-ravaged Eastern region, progressively affirmed itself. It provided a model for other similar agencies that were subsequently created in nine regions. To achieve economies of scale, a national purchasing agency, answerable to a board that includes public health authorities, local supply agencies and donors, was then established. Donors have provided start-up funds for each agency, and reduced their support thereafter. The declared aim of economic self-sufficiency might be within reach, given the potentially large efficiency gains of this setup.

In 2005, this centralised purchasing and decentralised distribution system, which had been endorsed by the national drug policy, supplied public health facilities and NGOs, in open competition with private for-profit dealers. It served about one third of the Congolese population. Plans existed to expand it to cover new areas. Although to consider it an unqualified success is premature, particularly in the volatile Congolese environment, the system nonetheless shows considerable promise. Starting on a small scale in order to respond to the collapse of general supply mechanisms, it has grown to become a central element in the recovery of the health sector, and a model to be considered outside the DR of Congo.

2002, where most decisions about the patterns of recovery were made with little input from NGOs, despite the crucial role they had played in delivering health services during the previous two decades of turmoil (Strong et al., 2005).

- Proceeding in isolation from other influential players. In the absence of reliable, comprehensive information about respective inputs and initiatives (ongoing and in the pipeline), actors are always vulnerable to this temptation. Many aid agencies have adhered to the Harmonization and Alignment agenda, thereby encouraging their country staff to pursue these ideals. However, powerful incentives against coordination still exist, particularly at country level.
  - Embarking on a transition process while maintaining mindsets, approaches, timeframes and tools better suited to an emergency environment, like projects, campaigns, special programmes.
  - Adopting inappropriate programming frameworks. For instance, at the beginning of 2005, the UN formulated a UN Transitional Plan for Somalia, designed to support ongoing, mainly recurrent expenses, over a twelve-month period. Activities were organized according to the MDGs, with inconsistent and sometimes bizarre results. Long-term outcomes, resulting from large investments, such as the MDGs, cannot accommodate the full range of interventions and routine activities required during the first year of a transition process.
- b. Health-related mistakes**
- Setting ambitious goals, such as the health-related MDGs, despite absolute under-financing. Donors may be reluctant to finance investment, because of sustainability concerns or of the bad reputation investment has earned. In reality, most countries emerging from conflict will only be able to expand the provision of health services through massive, long-term, sustained investments in hardware, human resources and management systems.
  - Focusing on cost-sharing mechanisms as the main device to close the funding gap. For most poor countries emerging from protracted conflict, this expectation has proved unrealistic, because of the severe destitution of its population and the difficulty of establishing and managing cost-sharing schemes. The related policy discussion tends to raise obvious equity concerns. What is often overlooked is that cost-sharing schemes may also be inefficient. First, their meagre returns may be partially or totally outweighed by the cost of operating them. Second, they depress demand for health care, leading to higher unit costs (against largely fixed inputs, like infrastructure and personnel). To compensate for decreased service uptake and hence revenues, providers increase fees, thereby further depressing demand. This vicious circle is recognisable in contexts where charging fees is the main or sole source of revenue for struggling providers, like in the DR Congo.
  - Looking for quick fixes, magic bullets, perfect solutions. Quick impact projects, so popular within donor circles, have been regarded with mounting scepticism by practitioners who stay long enough in country to witness the failure of these interventions. In some situations, quick



impact projects have political value, and can be upheld on that basis. Their contributions to the sustained expansion of health service coverage are mainly modest. Indeed, by absorbing important resources and attracting scarce capacity, in the long run their net effect on service delivery can even be negative.

The search for magic bullets may lead to excessive faith being placed in approaches with an intrinsic, if limited, value. That was the case in the past with community health workers, who were expected to become the cornerstone of health service delivery in rural areas, even in war-ravaged contexts. It seems now to be the case with contracting, an appealing strategy to regulate and rationalize health care in sectors where NGOs and charities are the main providers. The advocates of contracting have presented it as the main medicine to heal crippled health services. An important change in the software of service provision is unlikely to succeed, if key hardware shortcomings are left unaddressed.

- Failing to include special programmes in health recovery strategies. Special programmes often remain excluded from the policy debate about the characteristics of future health services. Resistance to restructuring special programmes, so that at least some of their functions are absorbed into mainstream operations, is usually strong. The integration of special programmes into general services has a poor record in post-conflict transitions. Starting with merging support components, like drug supply and financial management, might help to rationalize operations, without risking a breakdown of service delivery, or strong adverse reactions.
- Allocating aid according to field demands, in the absence of comprehensive recovery plans. Privileged situations, created by the successful intervention of NGOs and charities, are in this way strengthened. A vicious circle is established, with performing institutions tapping more resources, improving their reputation and hence attracting more patients, which will help them to gain additional support, while less efficient institutions are increasingly penalised.

Misplaced concerns about efficiency may reinforce this allocative bias, leading new actors to concentrate their efforts in areas where the costs of health provision are lower. Competitive schemes not taking into account the substantial differentials in delivery costs that exist within countries may contribute to the distortion of

health care provision within a recovering health sector.

- Concentrating attention on the service delivery point, while neglecting the support elements that make that delivery possible such as supply chains, financial and personnel management, training, etc. Additionally, first-referral hospitals may be neglected by the government (in favour of tertiary facilities), by donors supporting PHC provision, and by special programmes.
- Launching ambitious, detailed field inventories, covering most aspects of health service delivery. These studies can take months or even years to complete, and provide already outdated results when they finally become available. Additionally, during their implementation, important decisions may be postponed pending the outcome of the study. And given the difficulties surrounding their implementation, the results of these studies are often unreliable. Where capacity is in short supply, such studies carry heavy opportunity costs.

Examples of this wasteful approach abound. In 1992-93, a detailed review of rural hospitals in Mozambique provided little return because capital funding to invest in these facilities only became available in 1995-96. Field surveys had to be carried out again a few years later. In Sudan, an ambitious inventory of health services undertaken in 2003-04 gave rise to an impressive amount of data, which could not be collated because of an incompatibility between the formats employed. In Iraq, 1,600 health facilities were inspected during the spring of 2003 by a multitude of agencies. Given the variety of instruments and criteria applied, collecting and standardising these data was compared to 'herding cats' (Diaz and Garfield, 2003), and generated an analogous outcome. A similar exercise, undertaken in Afghanistan in 2003, yielded findings regarded as unreliable by most players.

- Binding the technical work needed to lay the ground for health sector recovery to political developments. In Southern Sudan, during 2004 and 2005, many activities aimed at preparing the recovery of the health sector came to a halt because of the Darfur emergency, the subsequent funding freeze and the transfer of donor capacity and resources to that crisis.
- Considering health issues in isolation from political, military, economic and cultural determinants. In fact, most decisions regarding health service recovery are taken outside the sector by politi-



cians, financiers and entrepreneurs, on grounds often unrelated to health concerns. Also, sustained efforts made within the health sector may be undermined by constraints outside it. For instance, human resource development may be thwarted by rigid, archaic provisions, maintained across the whole civil service (this was the case in Mozambique during the 1990s).

- Introducing initiatives that place heavy demands on scarce capacity, which should instead be concentrated on addressing issues of higher order and bigger impact. For example, establishing cost-sharing schemes in Southern Sudan, i.e. in one of the least served regions of the world, competed in 2003-4 with several other measures, like expanding service coverage, adding key components to the meagre service package provided, training competent health cadres, and so forth.
- Concentrating attention on fairly uncontroversial issues, while neglecting crucial ones, because of strong resistance and uncertain political implications. For instance, post-conflict recovery plans may focus attention on PHC services. Hospitals may be excluded from the planning process, as residuals to be considered later. Without restructuring plans, nor adequate financing to achieve it, the hospital network tend to become unbalanced, with some oversized facilities blessed by privileged funding lines, while the others are starved of resources.
- Promoting intensive in-service training programmes, in the misguided hope that they will address the shortcomings of a dilapidated workforce. Piece-meal in-service training has a poor record everywhere, even in favourable settings. In a post-conflict context, the shortcomings affecting health personnel are usually too severe to be corrected by short-term measures, like in-service training.

## 8. Guidelines for donors involved in post-conflict health recovery processes

Governments in power during periods of transition tend to be weak, particularly at local levels. Donors retain control over capacity and resources, particularly in fields of marginal interest to previous belligerents such as health. Many of the following recommendations assume the existence of a fragile post-conflict scenario, in which a weak government is struggling to survive. In such a situation, the role of donors is to support the delivery of services without undermining the emergence of local capacity

and leadership. Even in the most favourable settings, this calls for protracted donor engagement.

### a. Pre-conditions to be met in order to achieve adequate coverage of quality services

- **Intelligence** a genuine and accurate understanding of the events taking place within and outside the health field, and of their determinants. Many of the examples of best-practice cited above are rooted in a sound understanding of the situation, both at national and local level. Most mistakes are caused by the lack of intelligence, or by the overlooking of available information. Keeping the key insights about the status of health services at the core of policy discussions and regularly disseminating them is as important as delivering the health services themselves.
- **Adequate resource levels** that are guaranteed over prolonged periods. Most very poor countries emerging from conflict need aggregate health expenditures well above US\$10 per head per year, over at least 10 to 15 years, to ensure a balanced recovery. As shown in the table included in Chapter 3.2, few recovering health sectors have so far enjoyed these funding levels. Financial requirements will increase over time, as capacity and coverage improve. Given the parlous nature of most state budgets, and the impoverishment of the population, the bulk of this funding must be covered by donors, at least during the first years of transition. Aid should be determined by an evaluation of the likely costs of the recovery process, and not solely by the geopolitical importance of the country emerging from conflict. Adequate expertise should be devoted to monitoring aid patterns on a continuous basis, so that deviations from planned flows can be corrected or plans modified.
- **Security, political stability and adequate capacity.** Whereas the first two pre-conditions are likely to ebb and flow over time, adequate capacity should be ensured throughout the whole process, even when it is affected by serious setbacks.
- **Effective and efficient coordination mechanisms.** Coordination is regularly invoked as a key component of health service development. However, achieving effective coordination is difficult for several reasons. Coordination is labour-intensive and expensive. Its results are slow to materialize and success depends largely on the context in which it takes place and the actors involved. The sheer number and diversity of actors rules

out the possibility of achieving true consensus, so trade-offs are frequently required. Coordination is not an end, but a means. Without a robust, shared information base, vague, inconclusive and ideological discussions are the norm. The existence of a variety of different coordinating mechanisms / venues suggests that no single one works adequately.

Coordination does not necessarily equal large, ceremonial, frequently shallow meetings. It can be pursued in a variety of ways, including:

- i. *information*: by establishing information resource centres; by analysing and disseminating relevant information; by informal networking; by developing realistic and convincing policies, strategies and plans; and through coordination meetings.
- ii. *simplification and streamlining*: by reducing the number of players in a given area / field; by concentrating the attentions of agencies on specific fields, like drugs or HRD; by geographical zoning; and by adopting common standards, criteria and guidelines.
- iii. *effective and efficient aid management tools*: by establishing common management mechanisms; by creating trust fund(s); and by pooling external resources.
- iv. *monitoring and control*: by establishing a coordinating unit inside the government / MoH; by formulating codes of conduct, memoranda of understanding and operational guidelines for development partners. This approach is the least likely to succeed, given the weakness of government bodies supposed to control partners, and the autonomy enjoyed by the latter.

Effective coordination requires adequate resources, capacity and skills. Modest, informal, incremental measures are more likely to deliver results than ambitious, official mechanisms. Patiently and persistently experimenting with different schemes may prove a better approach than relying on a single mechanism. Selectivity is key: investing in promising coordination mechanisms, while staying away from hollow ones, must be a constantly held principle.

- **The willingness to take calculated risks.** A wait-and-see stance rarely pays off. Anticipating events is often better than responding to them. Failure, if documented and understood, teaches useful, if painful, lessons. Encouraging a pro-active, risk-taking posture among key players requires

the introduction of different organizational incentives within donor agencies.

In no post-conflict setting will all these preconditions be satisfied, particularly at the start of the process. Hence, the measures to be introduced and their sequencing will depend on the context, and the most serious constraints in place.

## b. Strategy and planning:

- **Try to inspire a post-conflict recovery process with convincing ideas**, rather than attempting to control it. In an environment crowded with autonomous actors, negotiation assumes a paramount role. However, in contexts where mistrust prevails and parties interact uneasily or not at all, including stakeholders in policy discussions is fraught with difficulties. The pursuit of inclusiveness at all costs may paralyse decisions or even fuel hatreds. Where aid is distributed unequally among belligerents who are still hostile to one another, it becomes part of the problem, rather than of the solution.
- **Be parsimonious with priority setting**, and with launching initiatives which require large capacity. Promote an informed, evidence-based discussion of the available policy options, without hiding their respective shortcomings and the likely side effects that may result from their introduction. Adjust the ambition of the policy discussion to the willingness, capacity and political capital of the emerging leadership. 'Big-bang' policy-making stands a chance of success in privileged post-conflict settings, where a new government enjoys a measure of legitimacy among large constituencies, as well as significant implementing capacity, as in Kosovo. Otherwise, ambitious policy proposals are likely to remain on paper, even if they are formally endorsed by weak governments eager to show they have a health policy, whose implications they may be unable to grasp.
- **Place equity considerations firmly at the top of the policy agenda.** Providing health services to the people who have suffered most from protracted violence (such as women, the displaced, the disempowered) should be an overriding concern. Mapping the delivery of health services country-wide, so that both privileged and neglected areas can be identified, helps to direct providers towards comparatively under-served areas. The cost differentials involved in delivering services in areas that are operationally demanding

need to be taken into account when budgeting new interventions. Donors should try to back their equity recommendations with adequate financing.

- **Place sustainability concerns into a long-term, realistic perspective.** A shift in the meaning assigned to sustainability is needed in the context of failed states, severe poverty and increased health needs. A country ravaged by protracted conflict and lacking basic resources and capacity is unsustainable and will remain so for long. 'Sustainable' health services are therefore those able to function on an uninterrupted basis, even if funded from external resources. In situations already marked by distress, crippling poverty and serious operational constraints, misplaced concerns about sustainability may foster further inefficiency and inequity.

It is also necessary to distinguish between different forms of sustainability. *Technical sustainability*, which relates to the capacity to carry out certain functions, should be distinguished from *financial sustainability*, which results from the availability of resources, fiscal capacity and the relative priority given to health care provision. A third dimension, which deserves consideration, is related to *political sustainability*. For instance, a necessary but unpopular policy may be abandoned by a government that is concerned about its tenure. Financial sustainability tends to take precedence over the two other dimensions in the eyes of many donor officials, perpetuating the assumption that adequate financing removes most or all obstacles.

- **Encourage the development of realistic sector-wide plans,** that are clear enough to set overall directions for recovery and later service expansion, but capable of accommodating unforeseen events and different partners with a variety of agendas. Over-programming and over-monitoring, while popular with donors, should be resisted, as misconceived and counterproductive.

Donors should not refrain from supporting policy discussions and the drawing-up of plans even in the absence of a functioning government. In such situations, a delicate trade-off must be reached between respecting the supported country and the need to deliver health services in a coherent, efficient and effective way. Donor agencies may be successful in fostering the emergence of policies, plans and operational instruments that are truly beneficial to the recovering country, provided that they:

- base the policy and planning work on a solid understanding of the situation in the health sector.
  - open the policy discussion to a variety of participants in the recovery process.
  - associate as many indigenous stakeholders as possible in the analytical work and in the subsequent decision-making process.
  - proceed in close collaboration with other donors, in such a way that the emerging policies, plans and instruments are not attributed to a single agency, or to a small cartel of them.
  - maintain an open communication channel with media, politicians, health professions and other emerging interest groups, so as to prevent misunderstandings and clarify them when necessary, take stock of the multiple interests and points of view, and contain the damage caused by political manipulations.
  - accept the inherently controversial nature of making decisions in politically-charged environments, and equip themselves accordingly.
- **Proceed with the technical groundwork needed to inform the policy discussion and the drawing-up of recovery plans,** even in the least promising environments. For instance, summary inventories of health facilities and of human resources should be completed and maintained even in the absence of a well-intentioned, legitimate government. Data about resources and service delivery patterns, if well organized and easily accessible, may help to make sound operational decisions, and foster a meaningful policy debate. Once an indigenous health leadership emerges, it will be able to take advantage of the analytical tools already available, and of the insights gained about main sector distortions, and related corrective measures.
- **Encourage the balanced recovery of the health care network** (first-contact facilities, referral hospitals, warehouses, training institutions and offices). Be prepared to support important investments, which are usually mandatory in dilapidated health sectors. Area-based planning (tightly linked to national resource ceilings) should be preferred over alternative approaches. First-referral hospitals, which often suffer the most as a result of protracted turmoil, require special attention, not least because of their critical role in tackling maternal mortality. Public financial management systems, HRD, supervision, drug procurement, and regulation are other vital



components of health service delivery that are usually neglected by donors and their programmes.

- ***Adopt a realistic, incremental approach to encourage the emergence of local capacity.*** In some contexts, as in southern Sudan, indigenous skills are so scarce, that long-term training programmes and imported expertise become inescapable. In other contexts, local talent is available, but is untapped or wasted within crippled institutions. In most cases, perverse incentives undermine the performance of health professionals. A successful capacity-building strategy will need to be grounded in a careful assessment of the interplay of skills, procedures, institutions and incentives. Building or restoring national capacity requires sustained efforts, made across the whole public sector.

#### c. Financial:

- ***Establish appropriate aid management tools*** to accommodate the contributions made by multiple financiers. These tools should be introduced early in the transition phase, or even before the end of hostilities, so that they are well established when aid allocations expand in support of the peace process. The traditional split between humanitarian and development funding should be overcome, in favour of flexible instruments able to support the whole range of expenses caused by the recovery process. The introduction of effective aid management tools entails a sizeable investment of capacity and resources over a significant period of time, and the exposure of funding agencies to criticism and political backlashes.
- ***Maintain some spare financing capacity to be managed in-country***, so as to be able to respond to unforeseen needs and/or to take advantage of precious opportunities, when they arise. For instance, following a ceasefire, previously inaccessible communities may be found in urgent need of support. Alternatively, regions neglected by humanitarian agencies because they were spared from the conflict may be found to be in a more precarious situation than those affected by the violence. Spare financing capacity, ideally pooled, can be instrumental in protecting vital processes from paralysis, when the attentions of the international community are absorbed by political hotspots, either in the country or elsewhere.
- ***Ensure un-earmarked funding to cover key expenses that are not paid for by other funding lines*** (as was done in Mozambique in the 1990s). Such

funding may start in a few pilot provinces in countries where the central government is regarded as too weak or too removed from the point of service delivery. These schemes of small scale at the outset may offer precious learning opportunities for donors, NGOs and local managers. They also provide a concrete space to experiment with decentralised decision-making.

#### d. Operational:

- ***Deploy experienced staff with the appropriate skills***, early in the transition from war to peace, and allow them to remain in post throughout the entire process. Negotiating capacity, sensitivity to context and understanding of institutions are skills sorely lacking in many agencies involved in post-conflict processes.
- ***Negotiate with partners and put in place as many standardising instruments as possible.*** Once these instruments are developed by experts and field tested, they need the backing of major funders, to ensure that they are adopted across the health sector by a range of implementers. As new organizations enter the country to participate in the recovery process, the availability of standards will greatly enhance the coherence and the effectiveness of operations. Also, these standards will be instrumental in introducing contracting arrangements.
- ***Set achievable challenges***, in such a way that participants gain confidence, learn by doing and build on previous achievements. Requirements must be set at modest levels in the early phases, when institutions are absent or weak and local professionals are inexperienced in the transactions they are expected to manage. As experience is gained and capacity grows, standards should be raised, so that they eventually conform to internationally accepted ones. Addressing serious problems with concrete measures is crucial, particularly at the beginning of a recovery process, when actors may feel too uncertain to take bold, system-wide steps. Small success stories may motivate stakeholders to tackle bigger problems.
- ***Maintain a variety of policy and operational instruments***, to respond to the changing environment and to overcome some of the multiple hurdles ahead. Reliance on a single or dominant funding tool, like general budget support or a trust fund, is too dangerous in most disrupted contexts. Encouraging multiple options allows health services to limp along if a major funding or supply mechanism stumbles, and gives decision-

makers the opportunity to appraise the merits of alternative approaches.

### e. Sequencing interventions

In every transition from war to peace, decision-makers face an intricate mix of challenges that range from satisfying immediate needs to putting in place the building blocks for future development. Most issues have to be addressed sooner or later (and some of them tend to worsen if neglected), despite limited capacity. The sequence by which interventions are introduced may therefore condition the ultimate success of the recovery process. Unfortunately, no best-practice exists for sequencing interventions in the messy and unstable context of a post-conflict transition. Also, most issues are linked, so that addressing them at the same time may offer clear advantages. Conversely, narrow interventions that do not address most constraints are likely to be ineffective, short-lived and costly.

Thinking of a recovery process as an iterative, never-ending learning exercise may be more productive than seeing it in terms of a one-direction movement. In this way, learning may start at different stages, and by tackling different issues. Provided actors are able to communicate, and allowed to collaborate, achievements in one area (say, policy formulation) will feed into another area (say, service provision). Gaps and shortcomings initially overlooked may be identified and corrective measures introduced. Initial mistakes may be corrected in light of new insights gained and lessons learned. The chart in Annex A tries to depict this iterative process in a simplified way.

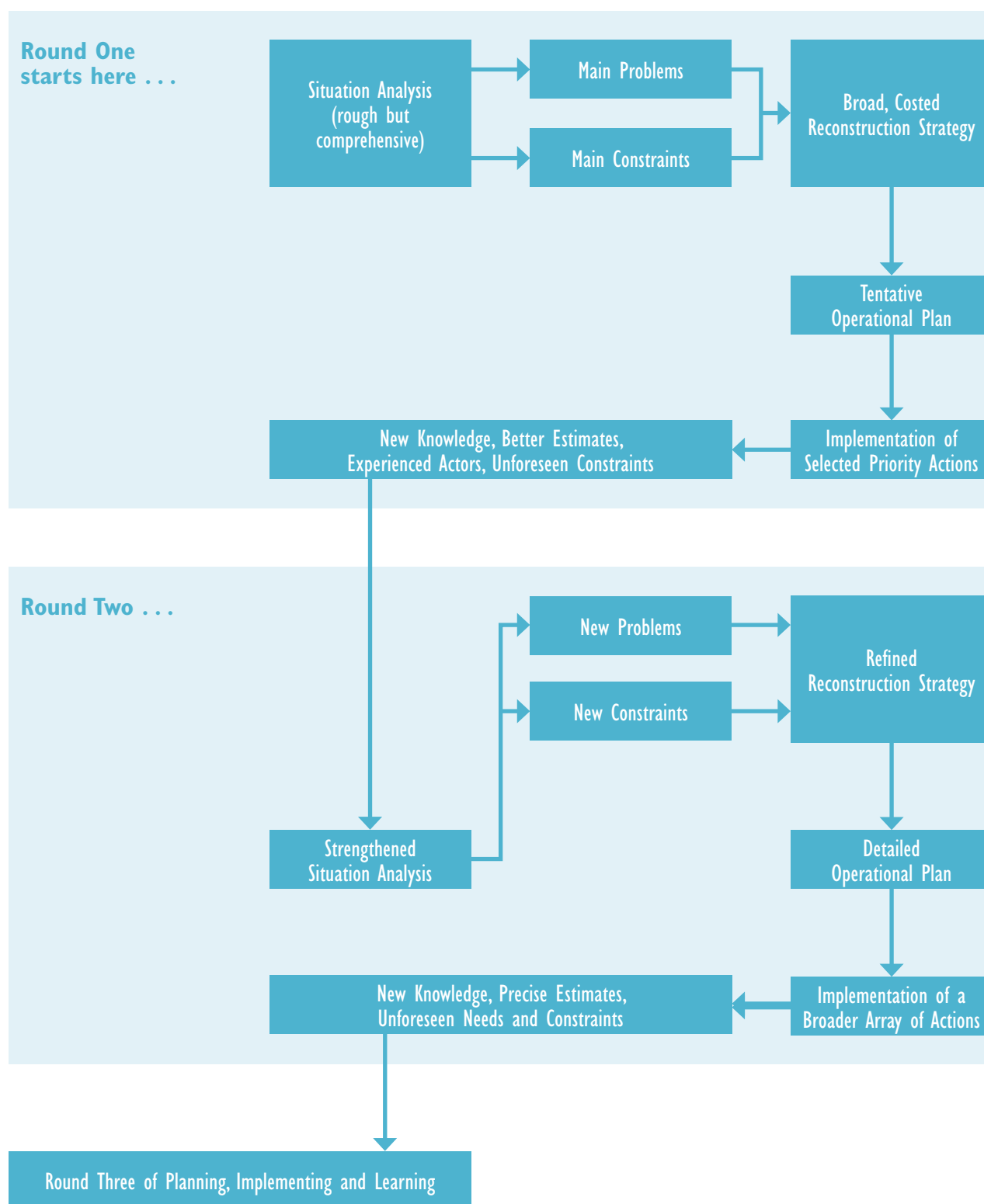
Principles that should be adopted when making decisions in relation to the sequence of interventions include:

- Start work early on standards and guidelines, so that they are in place when post-conflict funding starts flowing and old and new implementers expand their operations accordingly.
- Start early to address issues that demand prolonged efforts to provide tangible results. Given that restructuring a dilapidated workforce takes 10-15 years of sustained efforts, HRD should start as soon as possible and be given sufficient resources, to ensure that it proceeds relatively undisturbed, even in the presence of major hurdles in the recovery process.
- Start by studying contentious issues early and sketching interventions to assess them, so that they can be introduced as soon as a window of opportunity opens. This may happen in a later phase, when capacity, confidence and credibility have grown.
- Adopt a two-stage approach to recovery-oriented initiatives:
  - i. Proceed without delay with measures affecting important and adequately-understood problems. For instance, in 2004 midwives were extremely scarce in Southern Sudan. Therefore, work in this area could start in earnest, without waiting for the formulation of either a human resource development plan, or a comprehensive recovery plan.
  - ii. Refrain from launching initiatives in areas inadequately explored, where the costs of misinformed action are high or heavily influenced by pending political decisions. Instead, promote dedicated studies that seek to clarify the implications of the decisions to be taken.



## Annex A

### A recovery process as an iterative, learning, never-ending exercise



## Annex B

### Recommended reading (for the post-conflict health practitioner)

Banque Mondiale. *Santé et Pauvreté en République Démocratique du Congo: Analyse et Cadre Stratégique de Lutte contre la Pauvreté*. 2005.

A recent example of solid situation analysis, on which any serious policy discussion about health service delivery in the DR of Congo should be built.

Bower H. *Reconstructing Afghanistan's health system: Are lessons being learned from the past?* MSc. Dissertation. London School of Hygiene and Tropical Medicine. 2002.

A brilliant enquiry into the complexities of the Afghan health sector at a time of dramatic changes. Very perceptive discussion of policy-making and coordination in an extremely disrupted context. The relevance and applicability of experiences from abroad to the Afghan situation is realistically appraised. It includes valuable snapshots of the recovery processes of Uganda, Mozambique, Cambodia and Kosovo.

Collier P. *Aid, Policy and Growth in Post-Conflict Countries*. The World Bank. Conflict Prevention and Reconstruction Unit. Dissemination Notes Number 2. 2002.

Synthesis of an important ongoing research, which draws attention to several crucial findings. "Aid is considerably more effective in augmenting growth in post-conflict situations than in other situations". However, the way aid is provided has in many instances prevented the full tapping of this potential. In post-conflict environments, aid should also be preferentially directed to address social needs with commensurate social policies, at the expense of macro policies. A surprising priority ranking to be considered when aid is apportioned across competing demands.

Harmer A and Macrae J. (eds.). *Beyond the Continuum. The changing role of aid policy in protracted crises*. HPG Report 18. ODI 2004. Available online at [www.odi.org.uk](http://www.odi.org.uk).

Valuable review of recent trends in aid policy in protracted crises, which discusses the challenges posed to governments and international agencies by fuzzy environments, and the approaches and instruments emerging in response. UN agencies, IFIs and the US are discussed in detail. Essential reading for anyone involved in tracking and/or coordinating aid flows to a conflict-affected country.

Health Secretariat of the New Sudan. *Laying the grounds for the recovery of the health sector in a post-conflict Southern Sudan*. Second Draft. March 2004.

A long-term recovery strategy developed under pressure at the beginning of 2004, when the peace agreement for Sudan seemed imminent and stakeholders started exploring the health implications of the coming political deal. The main findings, goals and rationale of this strategy were later absorbed in the multi-donor Joint Needs Assessment finalised by the end of 2004. Despite this high-level endorsement, most of the measures recommended by the strategy to launch a recovery process started to be implemented more than one year later. A time lag between conception and implementation of policies of one or two years is commonplace in post-conflict settings.

Leader N. and Colenso P. *Aid Instruments in Fragile States*. PRDE Working Paper 5. 2005.

Macrae J. Zwi A. B. Birungi H. *A Healthy Peace? Rehabilitation and Development of the Health Sector in a 'Post'-Conflict Situation. The case of Uganda*. London School of Hygiene and Tropical Medicine. 1994.

A classic report, groundbreaking and very influential. Several of the patterns shaping transitional situations are described and critically discussed. A synthesis of the report's main themes is given by Macrae J. Zwi A. B. Gilson L. A Triple Burden for Health Sector Reform: 'Post'-Conflict Rehabilitation in Uganda. *Soc. Sci. Med.* Vol. 42, No. 7, pp. 1095-1108. 1996.

Noormahomed A. R. Segall M. *The Public Health Sector in Mozambique: A post-war strategy for rehabilitation and sustained development*. Macroeconomics, health and development series; no. 14. WHO 1994. Available online at: [http://whqlibdoc.who.int/hq/1994/WHO\\_ICO\\_MESD.14.pdf](http://whqlibdoc.who.int/hq/1994/WHO_ICO_MESD.14.pdf).

This reconstruction strategy, developed before the end of the war by the Ministry of Health of Mozambique, was published by WHO as 'best practice'. One decade later, it still deserves this title. Resulting from three years of studies and discussions and largely conceived by insiders, this document set a clear resource constraint for health sector recovery, planning what was at the time considered affordable in the long term. Its influence on the reconstruction process was vast. If the reconstruction of the health sector resulted in a (qualified) success, it was also because many autonomous actors tried vigorously to materialise the vision laid down in this document. Despite its age, recommended

reading to every stakeholder of a health recovery process.

OECD. Development Co-Operation Directorate. *Harmonisation and Alignment in Fragile States*. Draft Report by Overseas Development Institute (ODI), United Kingdom. 2004.

Pavignani E. and Durão J. R. Managing external resources in Mozambique: building new aid relationships on shifting sands? *Health Policy and Planning*. 14(3): 243-253. 1999.

Reduced version of the original research report, entitled "Aid, Change and Second Thoughts: Coordinating External Resources to the Health Sector in Mozambique". 1997. The evolution of emergency-oriented aid management tools, as the sector moved from a war to peace context, the emergence of new ones, the obstacles met, the enabling factors and the results achieved are covered by the report.

Pavignani E. and Colombo A. *Providing health services in countries disrupted by civil wars. A comparative analysis of Mozambique and Angola 1975-2000*. WHO. 2001. Available at: [www.who.int/eha/disasters/hbp/case\\_studies/case\\_studies.htm](http://www.who.int/eha/disasters/hbp/case_studies/case_studies.htm).

An exploration of the diverging evolution of the health sectors of two war-torn countries, which aims to understand the reasons behind their comparative success and failure. The challenges posed by and the lessons learned from the post-conflict reconstruction of Mozambique were discussed in relation to Angola and other countries embroiled in or emerging from conflict. Instructive for decision makers, health planners and aid officials called to face the dilemmas posed by protracted crises and transitions from war to peace.

Pavignani E. with Colombo A. *Analysing Disrupted Health Sectors. A Toolkit*. WHO. 2006 (*in progress*).

Developed to provide guidance to analysts of health sectors in crisis and emerging from crisis. Composed of 14 thematic modules, most of them relevant for the post-conflict health practitioner. Based on documented experiences, drawn from a variety of war-torn, as well as post-conflict, health sectors. To be finalised by mid-2006.

Poletti T. *Healthcare Financing in Complex Emergencies. A Background Issues Paper On Cost-Sharing*. LSHTM. 2003.

A refreshing discussion of a controversial issue. Almost two decades of experimenting with a variety of cost-sharing schemes in poor countries have produced lacklustre results. Despite the evidence collected in stable, poor settings, and the lack of it

in conflict-affected contexts, some donors were willing to condition their funding to health care projects implemented by NGOs in complex emergencies, to the inclusion of a cost-sharing component in their design.

The paper presents some documented cost-sharing mechanisms, under way in DR Congo and Liberia, finding them uniformly disappointing, in terms of revenue raising, efficiency and equity. Additionally, the paper offers a clear summary of the main sources of health care financing, of provider payment mechanisms, and of cost-sharing schemes.

Potter C. and Brough R. Systemic capacity building: a hierarchy of needs. *Health Policy and Planning* 19(5): 336-345. 2004.

Schiavo-Campo S. *Financing and Aid Management Arrangements in Post-Conflict Situations*. CPR Working Paper No. 6. The World Bank. 2003. Available online at [www.worldbank.org](http://www.worldbank.org).

Shuey D. A. Qosaj F. A. Schouten E. Zwi A. B. Planning for health sector reform in post-conflict situations: Kosovo 1999-2000. *Health Policy*, 63: 299-310. 2003.

Smith J. *Guide to health workforce development in post-conflict environments*. WHO 2005.

Comprehensive analysis of the main aspects of the subject, which helps to put human resource development where it should be, i.e., at the centre of any post-conflict health recovery process. The discussion is based on true field experience, gathered in several health sectors in transition, and is backed by a wealth of helpful examples and relevant literature. A welcome guide, which fills a serious gap. It should help participants in a recovery process to approach the human resource field equipped with true insights of the issues at stake. To be disseminated beyond the small circle of human resource specialists.

Tulloch J. Saadah F. de Araujo M. de Jesus R. Lobo S. Hemming I. Nassim J. Morris I. *Initial Steps in Rebuilding the Health Sector in East Timor*. National Academies Press. 2003.

Van Damme W. Van Lerberghe W. Boelaert M. Primary health care vs. emergency medical assistance: a conceptual framework. *Health Policy and Planning* 17(1): 49-60. 2002.

Clear review of the contrasting features that P. H.C. and E.M.A. should ideally present. Helpful to decision-makers and field practitioners, who might

be unaware of the conceptual underpinnings and of the practical implications of the two approaches. In most transitional contexts, P.H.C. and E.M.A. coexist in various mixes, in response to changing demands and pressures, organisational preferences, or sheer expedience. The conceptual clarity advocated by the paper, if fully grasped by actors, should discourage many misconceived measures, and the ensuing pointless debates about sustainability, accountability, inclusiveness and the like, which so often plague post-conflict work.

Williams G. and Hay R. *Fiscal Space and Sustainability from the Perspective of the Health Sector*. A background

paper for the High-Level Forum on the Health MDGs. The Policy Practice. 2005.

Insightful and realistic appraisal of issues of mounting relevance, presented in a way accessible to non-economists. Aid flows and government allocations for a group of thirty low-income countries are projected according to alternative scenarios. The conclusions are not rosy. Expanded aid flows will not be sufficient to boost health expenditure to the levels required to meet the health MDGs. Structural changes in the way donors and recipients finance health expenditure in poor countries are needed.

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## ENDNOTES

# Endnotes

## Section 1: Scaling Up Aid for Health

### 1. Resources, Aid Effectiveness and Harmonization

1 Examples are described in more detail in “The Millennium Development Goals for Health: Rising to the Challenges” World Bank 2003, which is available to order or to download from the World Bank website [www.worldbank.org](http://www.worldbank.org)

### 2. Harmonization and MDGs: A Perspective from Tanzania and Uganda

- 1 A notable exception is the HIV / AIDS MDG target, which Uganda has achieved: HIV prevalence is now at 6.2%, down from 18% in 1992.
- 2 Disentangling the effects of extra funds from those of efficiency gains is very difficult, but the MOH is convinced that increased output is a result of both.
- 3 *International Monetary Fund/International Development Association Poverty Reduction Strategy Paper Annual Progress Report*, Joint Staff Assessment prepared by staff of the IMF and IDA, 9 March 2001.
- 4 *Economic Report on Africa 2003 – Accelerating the Pace of Development*, UN Economic Commission for Africa.
- 5 In effect Uganda’s Poverty Reduction Strategy Paper (PRSP).
- 6 “Other charges” refers to non-salary items in the recurrent budget, including drugs, supplies and other operational expenditures.
- 7 Some stakeholders consider the rise in domestic resources for health too modest. Allocations to local government authorities of the Tanzanian Government’s subventions to health have stagnated in FY 2002/2003 despite “Other Charges” subventions being identified as a priority item in the PRSP.
- 8 Global Fund in Tanzania Mainland: HIV / AIDS: US\$ 108.7 million, HIV / TB 23.9 million, Malaria: US\$ 74 million as at April 2006.
- 9 Source: PRSP Review 2002, March 2003.
- 10 The Ugandan MOH has recently “shelved” a US\$15 million project proposal, where transaction costs were considered to be out of balance (mainly high technical assistance costs).
- 11 National Institute for Medical Research, Dar es Salaam.
- 12 Maternal and child mortality MDGs are not reflected as such in the Ugandan PEAP but proxy indicators are included (see Table 2).
- 13 This calculation did not include costing for a comprehensive antiretroviral (ARV) programme.
- 14 IMF website: <http://www.imf.org/external/np/vc/2002/060702.htm>
- 15 The assumption was that market prices for the vaccines concerned would drop significantly and that countries would be able to support their purchase in the post-GAVI period. This, however, has not been the case.
- 16 In 2002, 132 Tanzanian doctors left the country looking for greener pastures (Survey on Migration of Tanzanian Health Workers within and outside Africa, 2003). Brain drain of medical doctors is estimated as up to 30% of graduates in Uganda.
- 17 The annual intake of student medical doctors is too low to achieve the national health targets and donor agencies need to support in-service training. These issues were highlighted in the October 2003 Opening Address by the President of Tanzania at the 38th Scientific Conference and Annual General Meeting of the Medical Association.
- 18 Investment of both government and donor funds through the government budget.

### 3. MDG-Oriented Sector and Poverty Reduction Strategies: Lessons from Experience in Health

- 1 Albania, Benin, Burkina Faso, Cambodia, Ethiopia, Ghana, Guyana, Nepal, Nicaragua, Rwanda, Tajikistan, Tanzania, Uganda, Viet Nam.
- 2 WHO 2004, PRSP Synthesis Report; IMF April 2003. The ‘high case’ scenarios have not been directly related to achieving the MDGs, but the principle is the same.
- 3 Case Study material; WHO 2004, op cit.
- 4 World Bank, Ethiopia. First Poverty Reduction Support Operation, Programme Document, 23 January 2004.
- 5 World Bank, Nepal. PAD, Health Sector Programme, 4 August 2004.
- 6 See Dr Guy Hutton “User Fees and other determinants of health service utilisation in Africa: A review of formal and informal health sectors”.
- 7 World Bank, Mauritania Case Study (mimeo), quoting Ould Ahmed N and others, Mauritania HNP Country Status Report; and Ould Didi and others, MTEF Mauritania. Knippenberg et al (2003) report that application of the marginal budgeting for bottlenecks approach for preparing health MTEFs in Mali and Mauritania resulted in doubling of health budgets.
- 8 IEO IMF, July 2004
- 9 Soucat et al, 2002
- 10 Millennium Project, MDG Needs Assessment
- 11 Some of the private sector demand may be diverted to purchase imports, which would reduce the foreign exchange reserves and ease (but not eliminate) the excess demand problem. This complication is ignored for ease of exposition.
- 12 See Foster, Mick, “The Case for Aid”.
- 13 IEO IMF, 2004
- 14 IMF and IDA September 2003. This over-estimation of the available resources is just as serious as under-estimation, since unplanned shortfalls in resources may necessitate damaging short-term cuts in public spending, often focused on easy to cut non-salary recurrent budgets, resulting in disproportionate negative impacts on outputs by denying staff the resources to do an effective job.
- 15 IMF (2)
- 16 IEO IMF, 2003
- 17 See for example, Millennium Project, 2004
- 18 Foster, Mick, Full Report, 2004
- 19 Includes special programmes such as demobilization and reconstruction, which accounts for around 0.7% of GDP
- 20 Interest payment as % of GDP decreases from 6.2% in 2003 to 1.7% in 2008
- 21 These numbers are reported as total current revenue as % of GDP, capital revenue is recorded under the capital expenditure (net of capital revenue).
- 22 Due to missing data for some of the financing projections, projection target year is different (2004) for net external financing. IMF Executive Board completed Fifth and Sixth Reviews under Nicaragua’s PRGF arrangement (September 2004).
- 23 Interest payment as % of GDP decreases from 5.1% in 2003 to 2% in 2008.
- 24 These are data for net foreign borrowing. Grants are excluded due to missing projections for the programme years 2005 to 2010.
- 25 Data on programme target year not given in source document.
- 26 Hutton, op cit.
- 27 Several Millennium Project documents have made the same point.

## Section 2: Fiscal Space and Financial Sustainability

### 4. Fiscal Space and Sustainability from the Perspective of the Health Sector

- 1 The paper responds to an action point agreed by the HLF that requested “the World Bank and the IMF to clarify the concept of fiscal space and sustainability in the presence of long term grant funding and concessional lending at the country level and the implications for sector expenditure ceilings.”.
- 2 These figures do not include private expenditure on health, which usually exceeds public expenditure on health in low income countries.
- 3 These averages are weighted by population size and GDP.
- 4 If private expenditure on health is considered then six low income countries already reach a level of total health spending of \$34 per capita.
- 5 The budgetary arithmetic involved is captured by the following identity:  $PHE \equiv GDP \times PE / GDP \times H$ ; where PHE is public expenditure on health, GDP is gross domestic product or some similar measure of economic size, PE is total public expenditure and H is the share of total public expenditure allocated to health (see Hay, 2003).
- 6 The high spenders are likely to combine a strong underlying political preference for publicly financed services with substantial borrowing as low income countries generally tax less than 15 % of their economies. In addition, total public expenditure includes debt servicing. In many cases, debt servicing obligations amount to a significant proportion of total government expenditure.
- 7 The first is through budgetary reallocation towards the health sector. In principle this can be achieved ‘at the stroke of a pen’ by a high level political decision, although in practice matters are typically complicated by political issues. The second is by raising the ratio of public spending to GDP, either by increasing the tax base or tax rates or by borrowing. The former requires sustained effort. Fiscal performance is generally considered to be good if the tax-GDP ratio rises by 0.5 % per annum.
- 8 All aid figures are reported in 2002 constant dollars. The figures were derived from the OECD DAC Creditor Reporting System (CRS). They include aid recorded under purpose codes 120 Health and 130 Population. A substantial proportion of aid recorded under the CRS is not recorded by sector (for example, general budget support). It was assumed these commitments would be spent in the health sector in the same proportion as aid that is recorded by purpose code. The figures presented here are comparable to those quoted by Michaud (2003) and World Bank (2005), who report totals for all developing countries. Using the above method total development aid for health in all developing countries was estimated to be \$9.6bn in 2003 – the same as the figure reported by the World Bank (2005).
- 9 In the few cases where governments already spend more than 15% of their budgets on health it is assumed that there is no increase in the share of the budget allocated to health.
- 10 The Commission for Macroeconomics and Health calculates that total health expenditure per capita will need to exceed \$38 by 2008 in order to provide a package of essential health services. This figure includes private expenditure on health. It is very difficult to predict the effect of increasing public expenditures on private health expenditure. For the purposes of this analysis it is assumed that allowing for private contributions, public expenditure per capita on health would need to be in excess of \$30 in order to provide essential health services.

- 11 The expenditure targets calculated by the Millennium Project are somewhat higher than costings provided by the Commission on Macroeconomics and Health. In addition, the projections do not include private expenditure on health, which would help to somewhat narrow the gap.
- 12 Time series data was collected for net aid disbursements and public expenditure on health (both expressed as % GDP) for the period 1998-2002. The measures of volatility were constructed following the method of Bulir and Hamann (2005). A Hodrick-Prescott filter was applied to the time series data in order to distinguish between the effects of short term volatility and longer term trends and to calculate deviations from trend ( $\lambda=100$ ). The volatility measure is the natural logarithm of the variance of these de-trended values.
- 13 The effects also tend to be worse in countries that have decentralised their health budget management systems as funding stability is maintained by the centre at the expense of the periphery. Regional and district budget managers are typically unsure when or whether funds to finance non-staff recurrent expenditure will arrive. This makes them unreliable customers for local supplies of medical materials.
- 14 A forthcoming World Bank volume on health financing includes a model of resource allocation between levels of health care where aid is volatile and fungible. The model assumes that governments will be able to increase spending on higher levels of health care more easily than they can reduce spending. Hence an increase in donor funding for primary health care will tend to result in a rapid shift of government resources towards higher level health care. These funds cannot easily be returned in the case of a shortfall in donor support (World Bank, 2005). The model predicts that following a shortfall in donor funding the level of spending on primary health care would be lower than in the absence of aid.
- 15 Within the SWAP framework donors usually continue to provide funding in the form of projects, but there are also examples of pooled funding.
- 16 In Ethiopia and Mozambique external funding for HIV / AIDS in 2002-2004 was almost equal to the public health budget; in Uganda and Zambia it was significantly greater (Lewis, 2005).
- 17 Where better than expected health outcomes for income have been found, for example, Cuba, China, the Soviet Union, Kerala State and Sri Lanka in the 1980s, these seem to have been associated with extraordinarily strong political commitments to public investments in health, unusually high budget allocations and a highly motivated workforce. See also Keefer & Khemani, 2005.
- 18 The recent suspension of the GFATM programme in Uganda illustrates the risk of corruption in the context of large increases in donor funding.
- 19 If, however, public procurement simply replaced private drugs purchases then there would be a net increase in domestic demand.

### 5. Fiscal Space and Sustainability: Towards a Solution for the Health Sector

- 1 Such long-term commitments are under consideration by DFID. See Improving the predictability of aid flows: Proposals for action (DFID)-development finance team, Dec 2004
- 2 Wagstaff and Claeson (2004), p151.
- 3 Commission for Africa, 2005.
- 4 [Oecd.org/dataoecd/57/30/35320618.pdf](http://Oecd.org/dataoecd/57/30/35320618.pdf)
- 5 HDNHE, World Bank (2005), Health Financing Revisited, forthcoming.
- 6 Foster, Mick (2005)



- 7 Wagstaff and Claeson, op cit, p150.
- 8 Foster et al (2002).
- 9 Heller and Gupta, (2002).
- 10 For illustrations of this point for Ethiopia and Tanzania, see Foster et al, *The Case For Aid*, Volume 2.
- 11 For example, the 10 year DFID commitment to Rwanda has experienced disbursement delays associated with relations with DRC.
- 12 IMF / World Bank (April 2005 and September 2004) discuss a number of alternative mechanisms for financing global aid.
- 13 Kanbur, Ravi, 2004
- 14 Commission for Africa, op cit.
- 15 This section draws on the summary of the literature in Foster and Keith, op cit, Annex 2.
- 16 Bulir and Hamann.
- 17 Crown Agents (1); DFID (1); OECD-DAC (1) and (2).
- 18 This section draws on Foster, January 2005, op cit.
- 9 Waddington C. et al, *Trends in International funding for TB Control*. HLSP Institute and Stop TB Partnership Secretariat, London 2005; and Waddington C. et al, *Trends in International funding for Malaria Control*. HLSP Institute, London 2005
- 10 Pearson, ibid
- 11 GAVI bases its financial support to countries on national reporting systems verified by the Data Quality Audit. The Data Quality audit is a specific mechanism to evaluate and strengthen country reporting systems that measure immunized children.
- 12 The same considerations apply to initiatives like the US President's Emergency Plan for HIV/AIDS Relief (PEPFAR) and the World Bank's Multi-country AIDS Program (MAP) which share similar characteristics to the major GHPs (large-scale new funding, a focus on a single disease, and a drive for swift results) and raise similar issues about impact at country level.
- 13 Countries themselves may choose to take advantage of procurement pooling mechanisms or third-party procurement, in order to obtain economies of scale.
- 14 See <http://www.who.int/medicines/library/par/who-edm-par-99-4.pdf>

### Section 3: Global Health Partnerships

6. Global Health Partnerships: Assessing Country Consequences
- 1 Zambia, Uganda, Democratic Republic of Congo, Ethiopia, Tanzania, Mozambique, Burkina Faso, Guinea, Nigeria, Cambodia, Laos, Ghana, Angola, Yemen, Bangladesh, Vietnam, Kyrgyzstan, Chad, Indonesia, China.
- 2 Global Task Team WG2 on Harmonization of Technical Support (2005); UNAIDS at Country Level – Progress Report (Sept 2004)
- 3 Global Task Team WG2 on Harmonization of Technical Support (2005)
- 4 The Health Systems Strengthening window (HSS) at the Global Fund has now closed.
7. Best Practice Principles for Global Health Partnership Activities at Country Level
- 1 Including provisional findings from a large-scale current study by McKinsey & Co., commissioned by the Bill and Melinda Gates Foundation to provide an up to date assessment of the country-level perspective on global health partnerships and initiatives. The study focuses on the transaction costs at country level of multiple GHP interactions.
- 2 This section is based on: Dodd R and Cassels A *Applying the Paris Declaration to the health sector and to Global Health Partnerships*, WHO (2005)
- 3 *Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors*. Final report 14 June 2005, UNAIDS.
- 4 This study was commissioned by the Bill and Melinda Gates Foundation. Members of the HLF Secretariat participated in the study's Technical Advisory Group, and the study's provisional findings were presented to the HLF GHP Working Group on 28 September 2005.
- 5 *Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors*. Final report 14 June 2005.
- 6 Hacopian P, *Harmonization of Global Fund Programs and Donor Coordination: four case studies with a focus on HIV/AIDS*. GFATM, 2005
- 7 Carlson C. et al (2004) *Assessing the impact of Global Health Partnerships: Country case study report*. DFID Health Resource Centre.
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### Section 4: Health Systems

9. Tracking Resources for Global Health: Progress Toward a Policy Responsive System
- 1 From the 2004 Program of Work for the Secretariat of the High Level Forum on the Health MDGs
- 2 Supported by the Bill and Melinda Gates Foundation
11. Improving Health Workforce Performance
- 1 WHO estimates of health personnel 2002
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- 3 Kurowski C, Wyss K, Abdulla S, Yémadji N, Mills A. *Human resources for health: Requirements and availability in the context of scaling up priority interventions in low-income countries. Case studies from Tanzania and Chad*. London School of Hygiene & Tropical Medicine, 2003
- 4 Liese B, Blanchet N, Dussault G. *The human resource crisis in health services in sub-Saharan Africa*. World Bank, 2003
- 5 Couper I. *The ethics of international recruitment*. Department of Family Medicine and Primary Health Care, MEDUNSA, South Africa, 2002.
- 6 UNDP Human Development Report, 1992
- 7 Zarilli S, Kinnon C. *International trade in health services: A development perspective* UNCTAD 1998
- 8 Alcazar L, Andrade R. *Induced demand and absenteeism in Peruvian hospitals*. Latin America Research Network, Inter-American Development Bank 2001
- 9 World Development Report 2004, World Bank
- 10 CHD Report 1996-7, WHO
12. Working Together to Tackle the Crisis in Human Resources
- 1 The development of the Global Health Workforce Alliance, to be hosted by WHO, is now in Phase One with an anticipated launch in late 2006. The process is being managed by an Interim Board.

### Section 5: Health in Fragile States

13. Health in Fragile States: An Overview Note
- 1 Solomon Islands, Democratic Republic of Congo, Haiti, Sudan, Guinea Bissau, Nepal, Somalia, Yemen.